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Developing a Medicaid 1115 Waiver in San Francisco

Mitchell H. Katz, M.D., Director of Health, San Francisco Department of Public Health

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When national health care reform failed, many states and localities began developing their own efforts to create more comprehensive health service delivery systems — particularly for Medicaid (in California, Medi-Cal) beneficiaries. Thus far, 18 states have been given federal waiver authority ("Medicaid 1115 Waivers") to design innovative programs to address problems in publicly supported health and welfare programs.

These five-year, renewable, Medicaid 1115 waivers are essentially research and demonstration projects granted by the Secretary of Health and Human Services (HHS). Under the program, various requirements that normally apply in order for states to receive federal Medicaid funding are waived. Only states can apply for these waivers (a county interested in applying for a waiver must do so through its state department of health services). The Health Care Financing Administration (HCFA) within HHS oversees Medicaid 1115 waivers. States have used these waivers to expand health care to uninsured populations, implement mandatory managed care programs for Medicaid recipients and change reimbursement structures for providers, clinics and hospitals.

In 1996, California received its first Medicaid 1115 waiver to revamp Los Angeles County's health care delivery system. Los Angeles was facing a looming deficit—the waiver was designed to stabilize its safety net, reduce inappropriate hospital utilization, increase outpatient delivery settings, preserve trauma and emergency care systems and improve access. When the state was developing the Los Angeles waiver, state law was enacted which required the state to seek broader county participation in Medicaid 1115 waivers.

> "San Francisco is contemplating a Medicaid 1115 waiver. . .to create a more cost-effective way of providing health services to both Medi-Cal and uninsured residents."

The Department of Public Health submitted a proposed Medicaid 1115 waiver concept paper in the fall of 1996 on behalf of San Francisco. In the summer of 1997, the State approved San Francisco's concept paper and gave the county authorization to develop a complete waiver.

It was back in 1995 that the San Francisco Health Commission approved a resolution urging the Department of Public Health to pursue a Medicaid 1115 waiver to create a more cost-effective way of providing health services to both Medi-Cal beneficiaries and uninsured residents in San Francisco. Based on San Francisco's demographics, health indicators and service delivery system, the following goals were identified for a Medicaid 1115 waiver:

- Expand health care coverage to the uninsured: There are an estimated 130,000 uninsured San Francisco residents (working adults, non-working adults and children and youth) who do not have ready access to routine primary and preventive care.
- Enhance community-based outpatient services delivery system: While San Francisco has a sufficient number of providers, clinics and hospitals, maldistribution exists in the City and as a result some neighborhoods do not have access to primary care services.
- Restructure the delivery of long-term care services: Emphasize the use of community-based services for the elderly and disabled allowing them to remain integral parts of their communities which will prevent unnecessary utilization of institutional care and promote greater efficiencies.
- Propose an alternative Medi-Cal managed care model: San Francisco, with Medi-Cal managed care enrollment of 35,000 beneficiaries, is well below the state's threshold for participation (45,000), questioning the appropriateness of two competing health plans.
- Expanding home care services: Changes in the epidemiology of some diseases such as HIV and AIDS (with the introduction of new drug therapies and treatment regimens) will result in the

Continued on page 30.

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1115 Waiver—Katz

Continued from page 26.

need to improve access to home and community-based services for persons at risk of long-term care placement.

The department believes that redesigning the public and private delivery health systems will enable the county to develop a comprehensive health benefits package. The key denominator through the waiver is improving access. While San Francisco has been given the approval to develop a waiver, we are not committed to submitting a waiver on all the goals outlined above if further analysis indicates that the waiver would not be beneficial either programmatically or fiscally.

The San Francisco Health Commission has appointed a planning committee composed of providers, consumers, health care advocates, government agencies and other interested parties to effectively plan for submitting a waiver proposal. The department of Public Health will staff the committee's work. All committee meetings are noticed in advance and open to the public. Further information on San Francisco's waiver development can be obtained by contacting Ms. Tangerine Brigham, Director of Policy and Planning at the San Francisco Department of Public Health, (415) 554-2631.

Medical Rights/Tax Fairness

Continued from page 24.

some were in support, there was vocal opposition to this latter part of my proposal, and the House voted to accept the "softer" version by the reference committee. I was disappointed by this, but heartened by their support of action to safeguard patients' rights. I learned again the importance of lining up specific support ahead of debate, including speakers of like mind who will lobby their delegations and rise to speak in support of your resolution in front of the entire House.

My concern about patient privacy issues is that many doctors have given up on altering the rampant privacy invasions occurring in some managed care systems. Many physicians in administrative and review positions, now have conflicts of interest about these matters. I believe confidentiality and privacy protections are fundamental to our professionalism and to effective doctor-patient relations and genuine quality care. I hope that we physicians will renew our commitment to restore and maintain these fundamental civil rights of our patients. CMA and especially AMA will help greatly with this if enough of us express these views forcefully to the leadership. I'm glad to have had the opportunity to bring these issues before CMA's House of Delegates for debate and policymaking.

Dr. Walsh is a delegate to CMA, past-president of SFMS, and in the private practice of psychiatry in San Francisco and Mill Valley.

Hepatitus C Epidemic

Continued from page 29.

getting on the transplant list, even though they are free of street drugs and abstinent of any drug use other than that prescribed by a physician.

"The successfully maintained methadone patient is still viewed "a little like an unrepentant addict or something...I am interested in moving away from this addiction stigma into looking at people in terms of their ability to successfully self-regulate on a legal medicine prescribed by a licensed physician. Why should this patient be excluded from the transplant list?" he questioned.

John Irwin, PhD, who is a professor emeritus in sociology at San Francisco State University, is also a Hepatitis C patient currently on the liver list awaiting a transplant. He described the disease as "devastating" and then went on to say, "I had a vision of myself. . .as a person in very good shape. I had to quit surfing in the last year and I've had to accept the identity of becoming an invalid. . .I'm tired a great deal; my stamina's gone and I'm susceptible to different kinds of strange infections. For instance, I'm just getting over a case of shingles."

Joey Tranchina, MA, who directs syringe exchange projects in San Mateo and Northern Santa Clara Counties and serves as Director of Harm Reduction Projects for HCV Global Foundation, spoke about prevention. "What is true for HIV is equally true for HCV: prevention remains the only cure we have. Unfortunately, far too many syringe-exchange clients arrive at an exchange site already infected. Since this virus can be acquired early in a drug-using career, we must get the message out to young people that injection is a very dangerous experiment.

Pictured above is Dr. Steve Walsh urging the CMA House of Delegates to support his resolution on behalf of doctor-patient confidentiality.

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The Significance of a 1115 Waiver for SF Physicians

Edward A. Chow, M.D., Commissioner, San Francisco Department of Public Health

The Health Commission under the city charter has the responsibility to meet the health needs of the City. This is carried out through the Department of Public Health providing core public health services, mental health services, and a delivery system comprised of San Francisco General Hospital, Laguna Honda Hospital and the department's neighborhood primary care clinics organized as the Community Health Network (CHN). The department also contracts with many nonprofit and private health providers, including the city's hospitals and private physicians. Health delivery services cost nearly $400 million, while revenues, mostly from Medicare and Medicaid payments, amount to $300 million, with the gap filled by private payers or city general funds.

Over 100,000 residents are estimated to be uninsured in San Francisco. The lack of health coverage escalates the cost of care for this population, as access to preventive services and the treatment of illness is hindered by the lack of insurance. Expansion of health coverage to this vulnerable population through a Medicaid 1115 waiver may be a cost-effective way to improve access and the overall health status of this population.

I believe we share as physicians the common goal of improved health care access for our residents. The use of a Medicaid 1115 waiver could provide the opportunity for a locally redesigned system of care involving both the public and private sectors with a more comprehensive and culturally appropriate patient-centered system which would go a long way toward the ideal of universal coverage.

However, such a citywide initiative would require the participation and cooperation of both the public and private sectors. Following the permission of the state Department of Health Services to develop a Medicaid 1115 waiver, the Health Commission has formed a broad-based planning committee of consumers and providers, including the San Francisco Medical Society. The Commission will study the feasibilty of expanding health care coverage to the uninsured, enhancing a community-based outpatient delivery system, and improving the delivery of home care and long-term care and considering alternatives to the existing Two Plan model. The public and the provider community, including physicians, hospitals and community clinics, must take the opportunity to express themselves and participate in problem-solving. Only by frank and open discussions will we be able to overcome the questions that arise when there is the potential of change.

We have an opportunity to come closer to the reality of expanded health coverage for San Franciscans and an improvement in the overall health of our residents. I strongly encourage the active participants of all stakeholders, and am pleased that the San Francisco Medical Society has indicated its strong support of the goals of the planning committee and will be an active participant of this process.

> "A Medicaid 1115 waiver may be a cost-effective way to improve access and the overall health status of this [San Francisco] population."

CONGRATULATIONS TO DR. EDWARD CHOW WHO HAS BEEN REAPPOINTED TO A SECOND TERM ON THE SAN FRANCISCO HEALTH COMMISSION.

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MINUTES OF MEETING

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Wednesday, April 22, 1998
3:00 - 5:00 pm
Human Resources Commission Conference Room
25 Van Ness Building

PRESENT: Martin Diamond, Richard Gibbs, M.D., John Gressman, James Hickman, Carolayn Hughes, Mitch Katz, M.D., Amy Lee, Anthony Wagner, Mary Wong.

GUESTS: Nathan Nayman, Liz Strand; Celia Gaytan (for Guillermo Rodriguez); Carol Freels, Jan Smith, Daphne Kelly (for Janet Olson-Coyle); David Grant (for Bruce Livingston)

1. Consultant Contract Update

Tangerine Brigham announced that the Health Commission had approved the Pacific Health Policy Group (PHPG) as the 1115 waiver planning consultant. The consultant officially begins work May 1, 1998. PHPG is based in Claremont, California, PHPG has developed 1115 waiver proposals for several states and is very experienced in the planning process associated with an 1115 waiver. They have particular expertise in areas such as how specialized populations/services (e.g. HIV/AIDS) have been addressed in 1115 waiver planning

2. Balanced Budget Act - 1115 Waiver Implications

Richard Hodgson, Senior Health Planner, presented an analysis of those provisions of the Balanced Budget Act (BBA) of 1997 which could impact this waiver planning process. The written analysis provided in the agenda packet was reviewed with questions raised concerning the following BBA provisions:

- **Eligibility** - San Francisco's concept paper does not propose changing Medicaid eligibility criteria; the consultant, however, will be asked to provide input on the pros and cons of addressing eligibility issues.
- **The requirement to offer two managed care options to Medicaid participants** - Tangerine Brigham noted that this requirement is not in conflict with a County Organized Health System (COHS). Cal Optima in Orange County offers two as does the San Francisco Health Plan which offers Kaiser.
- **The Children's Health Insurance Program** - expansion of this program through BBA means that there will be fewer uninsured individuals to address through the 1115 waiver.

- **Additional funding for undocumented aliens** - at $25 million a year for the entire nation, this allocation is probably not going to have a significant impact.

It was noted that BBA provides flexibility to establish Medicaid managed care nation-wide but that an 1115 waiver is still required, because this waiver is not proposing to create managed care systems (this exists already for the population). We are trying to address issues that go beyond the BBA.

3. Guiding Principles

The draft guiding principles for the waiver planning process were discussed. The guiding principles set the framework for planning, and facilitate decision-making and the resolution of issues as the process moves forward.

It was also stressed that one of the first task of the committee will be to do a feasibility study on all aspects of the proposed concept paper. We should not pursue a waiver if it does not make sense.

The Committee had the following comments on this draft:

Principle 1

- define "access"
- delete "through the provision of appropriate levels of care"
- "home care" is not limited to HIV/AIDS but also addresses long-term care

Principle 2

- define key terms (e.g., "traditional provider")
- "preservation" implies the mere protection of what exists--is that what is meant and/or desired?

Principle 7

- add "linguistically-appropriate"
- delete "ready"

General

- Any proposed health care delivery system changes must recognize and address the labor implications--e.g., retraining and/or placement in new jobs of current workers may be required.
- HR3014 would create the opportunity for four new county-operated health systems (COHS) in California. San Francisco will pursue development of a COHS under that legislation if and when it passes. An 1115 waiver can provide more flexibility with respect to funding than perhaps a COHS obtained through the legislative route but the COHS also has advantages worth pursuing.
- It is unclear whether state-enabling legislation is required to implement a COHS.
- Developing community-based alternatives to institutional long term care is a waiver goal. However, even if long term care is not ultimately included in the

1115 waiver, the Long Term Care Pilot Project could still pursue its AB 1040 planning.

Staff will re-draft the guiding principles and circulate them to the Committee for review prior to the next meeting.

4. Workplan/Schedule

The draft workplan/schedule for the waiver planning process through September was presented. The schedule is based on PHPG's proposal submission and roughly identifies the work to be completed by September. Committee meeting dates/process milestones are identified. The draft will be reviewed with the consultant and brought back to the Committee for approval.

The Committee made the following recommendations regarding this draft:

- The public hearing indicated toward the end of this phase should receive comments that refine any draft submission. Community input on issues and the direction of the planning process will be obtained early in the schedule.
- The timeline should be corrected to show the proper order of committee meetings.

5. Proposed Subcommittees

Staff recommendations on three Subcommittees--System Design, Services Delivery and Financing and Data--were presented and the draft charges reviewed. The Subcommittees will meet in the alternate weeks between full Committee meetings.

The Committee accepted the staff proposal regarding the Subcommittees and made the following recommendations:

- Staff will re-draft the Subcommittee charges after meeting with the consultants to clarify task assignments.
- Subcommittee memberships should be drawn from outside the Committee as well as from within to assure the appropriate mix of skills and representativeness.
- There should be approximately 6-8 members per Subcommittee.
- All Subcommittee meetings, will be open to the public.
- All Subcommittees must have adequate consumer representation. Individuals who are on the "Interested Parties" list that was used to form the Committee will be contacted to determine their interest in participating on Subcommittees.

6. Community Input

The Committee asked staff to send out a draft list of proposed interviewees and a draft community input schedule for review. The process should utilize focus groups to obtain more detailed input from anticipated consumers into system design, accessibility, cultural/ linguistic competence and consumer satisfaction issues.

7. Long Term Care Planning

Anthony Wagner, Interim Executive Director of the Community Health Network, presented the progress to date of the Long Term Care Pilot Project Task Force. The Task Force has completed a draft system design proposal which will be reviewed in detail at an all-day Task Force retreat on April 24. Once finalized and approved by the Health Commission it will be submitted to the State for review. Implementation could take two years.

It is not clear at this time when and how an 1115 waiver will be pursued to implement long term care changes, but a waiver will likely be required and the planning for both should continue in parallel communicating frequently to track funding and clinical services issues of mutual concern.

8. Blue Ribbon Committee on Universal Health Care

A status report on the Blue Ribbon Committee's planning process was presented. A draft report will be submitted to the Blue Ribbon Committee for review next week. In brief, the report will propose implementing a phase--in with a smaller number of uninsured. The report requires several reviews and approvals and will be provided to the Mayor before any implementation is pursued.

9. General

The Committee requested that:

- All future agendas have a final item "New Business";
- The Blue Ribbon Committee's report be transmitted to this Committee as information at the appropriate time;
- The meetings should be expanded to 2-5 p.m. with the understanding that they may end before 5:00 p.m.
- Members should provide their fax numbers and e-mail addresses to staff.

Staff will continue to provide this Committee with relevant articles, reports and background information as they are identified. Committee members can call Tangerine

Brigham (554-2631) or Richard Hodgson (554-2627) at any time with any questions or requests they have regarding process or information.

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5/27/98

Health Commission

Medicaid 1115 Waiver Planning Committee Meeting

Wednesday, May 27, 1998
2:00 - 5:00 pm
25 Van Ness Room 330A

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AGENDA

Item		Process	Time
I.	Introduction/ Approval of April 22 Minutes		2:00-2:05pm
II.	Introduction of Consultants - Pacific Health Policy Group A) Review of Goals, Workplan, Process and Final Products of This Consultation B) Key Issues of San Francisco's Waiver Planning	Information/ Discussion	2:05-3:20pm
III.	Revised Draft Guiding Principles	Discussion/ Decision	3:20-3:35pm
IV.	Draft List of Consultant Interviews	Discussion/ Decision	3:35-3:50pm
V.	Status Report on Subcommittees A) Revised Draft Charges B) Membership Rosters	Discussion/ Decision	3:50-4:10pm
VI.	Updates: Blue Ribbon Committee on Universal Health Care, Long Term Care Pilot Project	Information	4:10-4:15pm
VII.	Calendar Planning - Member Availability for Interviews, Subcommittees	Discussion	4:15-4:30pm
VIII.	New Business		

Attachments:

- Minutes of April 22 8/27/98 mail out
- PHPG Organizational Biography/ Project Team
- Draft List of Consultant Interviews
- Subcommittee Membership Rosters
- Committee Meeting Schedule

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5/27/98

Health Commission

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1115 WAIVER PLANNING COMMITTEE
MINUTES OF MEETING
(Revised: June 23, 1998)

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Wednesday, May 27, 1998
2:00 – 5:00 PM
25 Van Ness Building, Room 330

PRESENT: John Borsos; Martin Diamond; Richard Gibbs, M.D.; John Gressman; James Hickman; Carolayn Hughes; Mitch Katz, M.D.; Amy Lee; Bruce Livingston; Nancy Presson; Guillermo Rodriguez; Robin Strimling; Anthony Wagner; Mary Wong.

GUESTS: David Ishida; Marie Jobling; Liz Strand; Celia Gaytan; George Babcock (for Janet Olson-Coyle)

1. **Minutes of April 22, 1998**

   Approved as submitted

2. **Introduction of Consultants—Presentation on Goals/Workplan/Process/San Francisco Issues**

   Consultants Cyndy Johnson and Mary Bading with Pacific Health Policy Group were introduced to the Committee. Cyndy Johnson presented information (attached for those not at the meeting) which summarizes San Francisco's current Medi-Cal demographics, describes the waiver organizational approaches of other states/counties, outlines suggested changes to this Committee's and its subcommittees' charges, and describes a workplan identifying Committee and community input milestones to complete the waiver planning process.

   She reiterated the Committee's basic charge, which is to evaluate the desirability and feasibility of pursuing various waiver options noting that a waiver should not be pursued unless it makes sense for San Francisco. She further noted that San Francisco should view the waiver planning process as a "clean slate"; other states have addressed similar issues but there is no requirement for San Francisco's approach to be the same as others. Ms. Johnson's other key comments were:

   a) Pharmacy will likely overtake inpatient services as the largest health services expenditure component within three years (as a result of managed care reduction of inpatient utilization and direct marketing of pharmaceuticals to the public).

   b) San Francisco's Medi-Cal population has a relatively equal division of age categories—not as many children as other areas of the country.

c) San Francisco is currently spending a very small amount (3%) of total Medi-Cal dollars on primary care.

d) Of San Francisco's Medi-Cal population, 2/3 is outside managed care (including the disabled, foster care children, etc.); a goal of the new system under a waiver could be to bring that 2/3 into managed care.

e) The term "1115 waiver" is a broad term for the Secretary of Health and Human Services' authority to waive Medicaid/Medicare regulations and authorize matching funds for populations not usually covered by those programs.

f) The goal of the waiver planning financial analysis is to demonstrate federal "budget neutrality" - i.e., that no more would be spent on Medicaid with the waiver than would have been spent without it over the 3-5 year life of the waiver demonstration project. Budget neutrality will be difficult for San Francisco to achieve because of the Medi-Cal cost reductions that have already been accomplished through managed care and other mechanisms. In reality, several earlier demonstrations have not been able to achieve budget neutrality.

g) "Carve outs"/Special Needs Plans (SNPs) are programs for potentially high-need populations such as HIV/AIDS that place either the population or its specialized services in a plan separate from the basic services package provided to the general recipient population. An important principle to remember when looking at special needs plans is to identify criteria for patients to get **out** of the SNP and return to the general plan, as well as criteria for getting in.

h) A primary goal of this consultation is to identify how San Francisco can achieve the flexible use of Medicaid dollars to improve access for indigent and low-income residents to needed health care and related services. An additional major goal is for the consultants to advise us regarding ways to increase Medi-Cal dollars (through funding stream consolidation, increased matching funds, etc.).

3. Committee Comments

Committee comments on the presentation were as follows:

a) Add in parentheses after Long Term Care on the Key Policy Issues slide - medical, social.

b) Should San Francisco include dental, hearing and vision services in its basic plan? How should mental health and substance abuse services be addressed?

c) Should San Francisco's waiver approach be comprehensive or incremental? Consultant recommendation: the approach should be incremental; San Francisco must learn from its early implementation phases.

d) Providing non-institutional supportive care to older immigrants is a particular problem for San Francisco.

e) What were the waiver implementation problems with Illinois, Tennessee and other states? We should obtain and review that information.

f) The planning schedule proposed is too ambitious. Additional time is needed to bring the Committee up to speed on waiver planning issues and the relationship of this activity to other major San Francisco health planning initiatives (Universal Health Care, Long Term Care Pilot Project, Healthy Families, County Organized Health System). In addition, more time is needed to get broad and diverse community input. The schedule should be extended through December.

g) Staff will provide the Committee with a list of "public input meetings" including hearings, focus groups and interviews. All Committee and subcommittee meetings are open to the public.

h) What are the target populations we are addressing? These must be clearly defined. How will the waiver planning process define "uninsured"? In identifying populations to address, we should build upon the PM² and Bindman studies of the uninsured.

i) How will waiver planning address eligibility? Other state waivers do not extend entitlement to those not eligible for Medicaid. The Los Angeles waiver expands access to Medi-Cal services and eligibility for them but not entitlement to them.

j) The Blue Ribbon Committee report on Universal Health Care and the Long Term Care Pilot Project Task Force report need to be understood better by this Committee and used to identify target populations and their needs. The consultant will help to determine whether it is advantageous to use a waiver to address them.

k) Do we want to expand entitlement (e.g., everybody up to 300% of the federal poverty level—children and adults)?

l) This committee needs some training on Medicaid and more information about what decisions it is required to make.

4. Revised Draft Guiding Principles

The Committee deferred further action on the Guiding Principles until additional community input is obtained through the interviews being conducted by the consultants.

5. Subcommittee Charges and Memberships

The Committee had no comments on the subcommittee rosters or on the revised charges. It did recommend, however, that no Subcommittee meetings be held until after the June 24 full Committee meeting at which there will be further clarification of responsibilities.

6. June 24 Committee Meeting

The Committee recommended that this meeting focus on:

- Training regarding Medicaid and waiver issues
- Achieving a better understanding of other San Francisco initiatives - Universal Health Care, Long Term Care Pilot Project, Healthy Families, County Organized Health System - and their relationship to waiver planning

Health Commission

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Medicaid 1115 Waiver Planning Committee Meeting

Wednesday, June 24, 1998
2:00 - 5:00 pm
25 Van Ness Room 330

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AGENDA

Item		Process	Time
I.	Introduction/ Approval of May 27, 1998 Minutes		2:00-2:05pm
II.	Relationship of San Francisco Planning Initiatives to Medicaid Waiver A) Universal Health Care B) Long Term Care Pilot Project C) County-Organized Health System D) Healthy Families	Information/ Discussion	2:05-3:15pm
III.	Orientation to Medicaid Waivers A) Planning and Approvals B) Options/ Waiver Requirements C) Serving New Populations D) Using Medicaid Dollars Differently	Information/ Discussion	3:15-4:30pm
IV.	Meeting Master Schedule Through December 1998 - Committee, Subcommittees	Information/ Discussion	4:30-4:40pm
V.	New Business		

Attachments:

Minutes of May 27, 1998 ~~0~~ 8/27/98 will send

May 27, 1998 Consultant Presentation (for those unable to attend) ~~0~~

Blue Ribbon Committee Report on Universal Health Care ~~0~~ Lit acquired this publication from DPH
(for those unable to attend May 27, 1998 meeting)

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1115 WAIVER PLANNING COMMITTEE
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Wednesday, June 24, 1998
2:00 - 5:00 p.m.
25 Van Ness Building, Room 330

PRESENT: John Borsos, Richard Gibbs, M.D., John Gressman, James Hickman, Carolyn Hughes, Mitch Katz, Amy Lee, Bruce Livingston, Shahnaz Nikpay, Janet Olsen-Coyle, Nancy Presson, Guillermo Rodriguez, Robin Strimling, Anthony Wagner, Mary Wong.

GUEST: David Ishida, Marie Jobling, Liz Strand, Celia Gaytan, George Babcock, Nathan Nayman, José Hernández, Manuel Rubio, Irwin Hoff, Jan Smith.

I. Minutes of May 27, 1998

- **Change** first sentence of 2.f: "The goal of the waiver planning financial analysis is to demonstrate federal budget neutrality.." to "The **requirement** of the waiver planning financial analysis is to demonstrate federal budget neutrality.."

- **Delete** last sentence of 2.f: "In reality, several earlier demonstrations have not been able to achieve budget neutrality."

- The LA waiver does not expand eligibility; it is a waiver for ambulatory care services

II. Relationship of San Francisco Planning Initiatives to Medicaid 1115 Waiver

Tangerine Brigham presented information (attached for those not at the meeting) describing other San Francisco planning initiatives—Universal Health Care, Long Term Care Pilot Project, County Organized Health System, Healthy Families—and their relationship to Medicaid 1115 waiver planning.

Concerning Universal Health Care, the Committee asked for clarification regarding which populations would be covered under the Purchasing Alliance and which would be covered under an 1115 waiver. It was noted that which populations can be covered under a waiver is driven by the savings achieved under the budget neutrality requirement, not the percent of Federal Poverty Level of the client's income. This Committee will look at the populations identified by the Blue Ribbon Committee on Universal Health Care and recommend which should be included under the waiver. The Committee requested a copy (attached) of the analysis of San Francisco's uninsured completed for the Blue Ribbon

Committee. It was noted that mandatory 6 months residence could be required for Purchasing Alliance services but the Welfare and Institutions Code Section 17000 requirement will still be adhered to.

Regarding long term care, the Long Term Care Pilot Project's ultimate goal is capitated managed care after implementing a 3 year fee-for-services managed care phase-in focusing on improved coordination of long term care services and data collection on costs and services utilization that will be useful in developing capitation. The project will also consolidate the many currently duplicative intake processes into one. Arizona is the only state with a full-scale long-term care 1115 waiver; it has been in place for 10 years.

There are currently 5 County-Organized Health Systems and HR3014, if passed, will authorize the creation of 4 more. A COHS covers all Medi-Cal recipients in a county. Regarding a COHS for San Francisco, HCFA's policy position is that there must be plan choice (at least two plans) available to Medicaid enrollees in a county. It was also noted that the support of the provider community from the outset was essential to the success of the current California COHSs.

Because of the long lead time to implement, Medi-Cal enrollments and the economy could be very different by the time an 1115 waiver is implemented in 2 – 3 years.

Regarding Healthy Families, there have been significant problems in implementation to date.

At the next meeting, the Committee will focus intensively on the populations in the aforementioned planning initiatives that should be considered for inclusion in an 1115 waiver.

III. Orientation to Medicaid Waivers

Andrew Cohen (Pacific Health Policy Group) presented information defining the 1115 waiver and what can be accomplished under one. He noted that an 1115 waiver to limit freedom of choice could limit both consumers' choice of providers and the number of providers participating in a plan. The option to waive Federally Qualified Health Centers (FQHCs) cost-based reimbursement has been highly controversial; to date waiver proponents have been required to get FQHCs to buy into gradual reductions and this has been difficult. Regarding Disproportionate Share Hospitals (DSH) funds, half the states have "dollars follow clients" policies (i.e., dollars go to the plan in which the client is enrolled); half the states separate DSH dollars from managed care capitation and provide them directly to the disproportionate share hospitals. It was reiterated that the State must submit the waiver; a county can not submit one. HCFA interacts with the State on waivers. California is exploring the possibility of consolidating all county waivers into one State waiver at some point.

The Mobile County, Alabama waiver was discussed: it is a COHS-style waiver with 50,000 enrollees. It is a single plan model for all Medicaid enrollees (unless they actively seek exemptions) which converted all fee-for-service to managed care. The single plan includes all providers including FQHCs to address HCFA's concern about provider choice. The state requires budget neutrality as well as HCFA and they are banking the savings instead of expanding coverage. The model was approved for 5 years with an evaluation at 3 years. Robin Strimling from HCFA noted that HCFA would not favor establishment of another Mobile-style model unless the limitation of plan choice can be addressed.

The Committee asked about the research and demonstration component of the 1115 waivers. Currently, it is being emphasized more for long term care than other models, but San Francisco's waiver would require such a component. For example, San Francisco could evaluate non-traditional risk adjusters or services delivery related to the relatively unusual aging demographic of its population.

New York's waiver was able to draw down federal matches for IMD, CHIP and other programs resulting in an additional $1.25 billion over 5 years. New York was able to achieve this based on its fiscal analysis and strongly advocating its case to Administration officials and political bodies. New York also extends Medicaid coverage to non-Medicaid eligibles.

It was noted that the required waiver document section on Public Notice and Community Support is very important in the evaluation process. A Management Information System (MIS) for waiver administration linking the State and County is also important to track progress and budget neutrality. It was also noted that savings achieved under the 1915b waiver (managed care) can not be used under the 1115 waiver—so the ceiling for potential savings has already been lowered.

Due to the time, the remainder of Mr. Cohen's presentation was deferred to the July 22 meeting starting at item 5, Evaluation of Existing Waiver Programs. Committee members are asked to bring the handout entitled "1115 Waiver Committee" from this meeting to the July 22 meeting.

Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, July 22, 1998
1:00 – 4:00 p.m.*
25 Van Ness, Room 330

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AGENDA

Item		Process	Time
I.	Introduction/Approval of June 24, 1998 Minutes	Action	1:00 - 1:05pm
II.	Orientation to Medicaid Waivers (Continued) ** a) Evaluation of Existing Waiver Programs b) Blue Ribbon and Long Term Care Task Force Reports: Key issues to be Considered By this Committee c) Summaries of Issues Raised in Constituent Interviews	Information/ Discussion	1:05 – 2:30pm
III.	Populations for Potential Inclusion in a 1115 Waiver	Information/ Discussion	2:30 – 3:30pm
IV.	Draft Guiding Principles	Discussion	3:30 – 4:00pm
V.	New Business		

Attachments:

- Minutes of June 24, 1998
- Analysis of San Francisco's Uninsured
- San Francisco Planning Initiatives (for those unable to attend June 24)

*** MEETING TIME CHANGED TO 1:00 – 4:00 PM FOR THIS MEETING ONLY**

****PLEASE BRING YOUR HAND-OUT FROM JUNE 24 ENTITLED "1115 WAIVER COMMITTEE" TO THIS MEETING**

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Health Commission

MEDICAID
1115 WAIVER PLANNING COMMITTEE
MINUTES OF MEETING

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Wednesday, July 22, 1998
2:00 - 5:00 p.m.
25 Van Ness Building, Room 330

PRESENT: John Borsos, Martin Diamond, Richard Gibbs, M.D., John Gressman, James Hickman, Amy Lee, Bruce Livingston, Janie Tyre (for Shahnaz Nikpay), George Babcock (for Janet Olsen-Coyle), Nancy Presson, Celia Gaytan (for Guillermo Rodriguez), Mary Wong.

GUESTS: Merrill Buice, Irwin Hoff, David Ishida, Jan Smith, Liz Strand, Nathan Nayman

I. Minutes of June 24, 1998

Approved as submitted.

II. Orientation to Medicaid Waivers (Continued)

Cyndy Johnson, consultant - Pacific Health Policy Group (PHPG), continued the orientation to Medicaid waivers initiated at the last meeting by Andrew Cohen of PHPG. She reiterated some of the key points (summarized in the June 24 meeting minutes) from Mr. Cohen's presentation for those who had not been able to attend the last meeting. After she reviewed waiver guidelines and the waiver approaches of other states, the Committee asked the following questions:

1) Have any waivers reduced services? Answer: Generally, it is politically not feasible to reduce services through a 1115 waiver; Oregon and Tennessee, however, could be said to have reduced services through their waiver programs.
2) How was New York's small business health partnership received? Answer; Initially, it was not well received because it was perceived as giving participating businesses an unfair advantage over those not participating.
3) How did New York get health care dollars for worker re-training? Why not Department of Labor dollars? Answer: New York made a case based on massive restructuring of its health care system. Without the retraining component, the waiver would not have gone forward.

Ms. Johnson continued by reviewing PHPG's evaluations of several waiver programs that had been in effect long enough to produce measurable results - i.e., Hawaii, Rhode Island and Tennessee. Discussion focused on Tennessee's program where the State did not produce the dollars to draw down the federal

match. (State/ local dollars must be spent first, before federal matching dollars can be.) Competing expenditure priorities and a change in State administration resulted in less State dollars going to the 1115 waiver than the originally approved.

Ms. Johnson also noted several key general points regarding 1115 waivers:

1) County administration of a waiver is problematic vis a vis state administration for political reasons: if a waiver approach is a good idea for several areas of a state, why is it not being implemented in all the counties where it could have a positive impact?
2) The greatest "savings" achieved under waiver budget neutrality have been achieved in the initial shift from fee-for-service to managed care. To achieve additional savings, San Francisco must consider whether to extend managed care/ primary care case management concepts to the aged, blind and disabled - the Medicaid aid categories in which the most dollars are spent.
3) HCFA has approved flatter expenditure growth rates in recent years than it did for earlier waivers. Annual growth rates of 10%-12% are no longer being approved; rates in the newer waivers tend to be around 3%.
4) The budget neutrality cap in a waiver sets the upper limit of federal spending for Medicaid during a waiver project period.
5) Many states (not just California) are having problems implementing the Children's Health Insurance Program (CHIP - Healthy Families in California) because of long and complicated enrollment applications and cumbersome eligibility screening processes.
6) Providing "standing referrals" to specialists for those who need regular specialist care is one of the ways managed care is improving services to high-need populations.
7) Individual premium collection in a low-income health care coverage program is more trouble than it is worth; standard deduction from paychecks is the most efficient way to collect premiums.
8) Missing the mark on an 1115 waiver budget neutrality analysis is easy to do; numbers are often shaky to begin with given the many uncontrollable variables and the problem is compounded by the unpredictability of levels of participation.

Ms. Johnson continued by reviewing the highlights of PHPG's summary of the constituent interviews conducted in San Francisco in June. The Committee focused on the following issues:

1) Do we want to move away from employer-based coverage? It is possible many employers would support this as providing health insurance is a major headache for many small employers. Crowd out, however, would be a significant issue at the higher income levels.
2) 1115 waiver budget neutrality is not necessarily the limiting factor in extending coverage to the uninsured. Other sources of funds could be identified and linked with 1115 savings to create a viable plan.

3) Re Los Angeles County's waiver, it is important to note that the match to the federal dollars is a County match, not a State match. (The Committee requested copies of a summary of Los Angeles County's waiver.)
4) The Committee would like a presentation on budget neutrality at its next meeting. Budget neutrality and how San Francisco addresses it are the keys to the feasibility of a waiver and how San Francisco's objectives are to be achieved.
5) Significant health care system redesign would undoubtedly have negative impacts on some of the current stakeholders. It is important to identify those negative impacts and develop a strategy to address them.
6) We need to concentrate on developing the ideal delivery system and the design will create the necessary savings for budget neutrality. Our plan should be graduated with different levels of implementation creating successes that lead to the next level.
7) The limiting factor in achieving budget neutrality could be the availability of the local match. Existing local expenditures (with no augmentation) are the first priority for establishing the local match.
8) It is important to note that administration and services have different federal match rates.
9) The waiver planning process should focus on increasing access, not just coverage. Health insurance coverage alone will not improve health status if clients can not access the providers they need. Significant copayments, geographic and cultural/ linguistic barriers, and other roadblocks to service access may remain even if insurance coverage is extended.
10) Because of San Francisco's aging and poverty demographics, we should look at including Medicare/ Medi-Cal dual eligibles under a 1115 waiver even though that may be difficult to achieve.

III. Populations for Potential Inclusion in a 1115 Waiver

Richard Hodgson presented a draft list of populations for potential inclusion in a 1115 waiver for San Francisco. He noted that this list is a first cut representing some populations suggested by several groups; no decisions have been made on which populations to include and the list is not complete. The Committee suggested adding the dual eligibles (described above) and the underinsured to 300% FPL to the list for consideration. Mr. Hodgson asked the Committee members to suggest in writing additional populations they think ought to be included and why. This subject will be continued at the next meeting.

IV. Draft Guiding Principles

There were several comments requesting significant changes to the current draft of the Guiding Principles. The Committee asked that an ad hoc task force be appointed to review the document and recommend appropriate changes at the next meeting.

SF Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

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Wednesday, August 26, 1998
2:00 – 5:00 p.m.
25 Van Ness, Room 330

AGENDA

Item		Process	Time
I.	Introduction/Approval of July 22, 1998 Minutes	Action	2:00 - 2:05pm
II.	Budget Neutrality: Requirements And Strategies For Achieving It	Information/ Discussion	2:05 - 3:05pm
III.	Populations for Potential Inclusion in a 1115 Waiver (Continued)	Discussion	3:05 - 3:45pm
IV.	Draft Guiding Principles (Continued)	Discussion	3:45 - 4:20pm
V.	New Business		

Attachments:

- Minutes of July 22, 1998
- Articles of Interest Re 1115 Waiver Planning
  - Excerpt from "Statewide Medicaid Managed Care Demonstrations Under Section 1115" (good evaluation of the 1115 waiver program to date)
  - "Family Coverage Options Under CHIP" (how to expand Healthy Families using a 1115 waiver)
  - "Reinventing Medicaid for persons with HIV" (how to use a 1115 waiver to establish a prevention/ early intervention program)
  - Summary of and articles relating to Los Angeles County's 1115 waiver
  - Waiver programs to date - map (HCFA web site noted has descriptions of each state/ locality 1115 waiver project)

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Health Commission

MEDICAID
1115 WAIVER PLANNING COMMITTEE
MINUTES OF MEETING

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SEP 18 1998
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Wednesday, August 26, 1998
2:00 - 5:00 p.m.
25 Van Ness Building, Room 330

PRESENT: Merrill Buice (for John Gressman); Celia Gaytan (for Guillermo Rodriguez); Richard Gibbs, M.D.; Carolayn Hughes; Shahnaz Nikpay; Janet Olsen-Coyle; Nancy Presson; Robin Strimling; Tony Wagner; Mary Wong.

GUESTS: George Babcock; Larry Bernstein; Donna Calame; Jeanne Finberg; Carol Freels; David Ishida; Marie Jobling; Ivana Kirola; Nathan Nayman; Anthony Nicco; Liz Strand

I. Minutes of July 22, 1998

Approved as submitted.

II. Budget Neutrality: Requirements and Strategies for Achieving It

Janet Olsen-Coyle, State DHS Medi-Cal Policy Division, presented the requirements for budget neutrality analysis under a 1115 waiver and several strategies for achieving it. Robin Strimling, HCFA Regional Office, provided additional insights from HCFA's perspective.

Below please find several points Ms. Olsen-Coyle emphasized as she presented comments related to her outline:

- **Financing Principles**

1) Cost savings already attributed to existing 1915a, b and c waivers can not also be applied to a 1115 waiver. New savings must be found even if in the same cost categories.
2) Federal DSH dollars can not go into a pool subject to local re-allocation.
3) DSH dollars can not be matched to populations but have to be matched to actual services provided.
4) Inpatient dollars can not be used for outpatient services although one of the goals of managed care is to reduce inpatient hospitalization by providing more services on an outpatient basis.
5) Generally, a 1115 waiver can not supercede DSH law and regulations.

- **General Rules to Follow**

1) It is important to note point 8.under "General Rules": a jurisdiction's "without waiver projections" should include only program components that are already included in the State Plan.
2) If the federal government excludes a population from eligibility, that population can not be included under a 1115 waiver.

- **Calculating Budget Neutrality**

1) Use historical and projected expenditures for **all** San Francisco Medi-Cal providers.
2) As a rule, administrative expenses for both the State and local jurisdictions are included under a waiver's budget neutrality cap. (L. A.'s administrative expenses are outside its budget neutrality cap.)

- **General Comments on Budget Neutrality**

1) Although the rules regarding budget neutrality calculation appear well-defined and firm, in actual practice they are negotiable. For example, L.A.'s waiver was developed in response to a severe County fiscal crisis and some of the financing rules were waived or modified to permit a "bail out" of the County's health system.
2) In addition to budget neutrality calculation rules, an individual jurisdiction's planning assumptions are subject to negotiation with HCFA to address major issues in creative ways.

- **Potential Medicaid Cost Savings Concepts**

1) The most significant areas for achieving cost savings in service delivery are through reduced acute and long term hospitalization and reduced use of the emergency department as a source of primary care.
2) Innovative cost savings strategies can still be applied to managed care as well as the remaining fee-for-service population.
3) Extending managed care/ primary care case management to the aged, blind and disabled on a mandatory enrollment basis and applying disease/ case management concepts to high needs, high service-utilizing chronic disease patients (e.g., congestive heart failure, asthma, diabetes, hypertension) are two potential cost savings strategies.

III. Populations for Potential Inclusion in a 1115 Waiver (Continued)

Richard Hodgson presented a revision of the list of potential populations to which health care coverage might be extended with the savings achieved under a 1115 waiver's budget neutrality cap. He noted that no savings have been identified to date; the consultant is currently working on the analysis of San Francisco's Medi-Cal historical utilization and costs, the first step in developing the budget neutrality analysis.

The Committee discussed how the list of potential populations might be prioritized and offered the following recommendations:

1) San Francisco should consider identifying Medi-Cal and other indigent client populations that are disproportionately high cost, high service utilizers and developing service strategies to improve and maintain their health through less costly prevention/ early intervention/ primary care. Approximately half of all health care dollars are spent on chronic disease care and prevention and early intervention in disease processes could both improve health status and save money.

2) The "underinsured" and the services they might require are difficult to identify and vary widely depending on which sub-group of that population is being considered. Accordingly, given the more clear-cut and pressing needs of the completely uninsured as identified by the Mayor's Blue Ribbon Committee on Universal Health Care, the underinsured should be considered as a lower priority population for inclusion in the waiver.

Staff will provide estimates of population numbers on the next draft of the potential populations list. The discussion of this matter will be continued at the next meeting.

IV. Draft Guiding Principles (Continued)

The re-draft of the Guiding Principles based on the Committee's comments at the last meeting was presented for consideration. The Committee requested one additional change:

- Add to 8. the change indicated in italics: ... "will result in improvements (either fiscal, programmatic, *quality of care* or structural) in San Francisco's health care delivery system."

With the incorporation of the above-indicated change, the Committee approved the Guiding Principles and requested that the final version be distributed to the Subcommittees.

Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, September 23, 1998
2:00 – 5:00 p.m.
25 Van Ness, Room 330

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AGENDA

Item		Process	Time
I.	Introduction/Approval of August 26, 1998 Minutes	Action	2:00 - 2:05pm
II.	Analysis of San Francisco's Historical Medi-Cal Utilization and Costs	Information/ Discussion	2:05 - 3:30pm
III.	Populations for Potential Inclusion in a 1115 Waiver (Continued)	Discussion	3:30 - 4:15pm
IV.	Committee and Subcommittee Schedules and Workplans Through December 1998	Information/ Discussion	4:15 - 4:35pm
V.	New Business		

Attachments:

- Minutes of August 26, 1998
- Pacific Health Policy Group memo re Medi-Cal eligible populations and services/ potential expansion
- Excerpt from "Medicaid Survival Kit" on eligible populations/ services
- Budget neutrality hand-outs (for those unable to attend August 26)

THE PACIFIC HEALTH POLICY GROUP

Client Memorandum

TO: Tangerine Brigham

FROM: Andy Cohen

SUBJECT: Medi-Cal Eligibility and Services

DATE: September 4, 1998

CC:

As you requested, I'm writing to give you information regarding eligible populations and covered services in the Medi-Cal program, and how either or both could be expanded under a waiver.

Eligible Populations

The Title XIX program separates populations eligible for federal matching dollars into two groups: 1) mandatory (those that all states must cover); and 2) optional (those that states may cover, at their discretion).

The mandatory eligible groups, which are also referred to as "categorically needy" (i.e., automatically qualifying because of their linkage to another category of public assistance, such as food stamps), include:

- TANF (formerly AFDC) recipients (including certain groups not eligible for cash assistance)
- SSI recipients
- Women during pregnancy and sixty days postpartum, in households with income below 133 percent of federal poverty
- Children up to age six, in households with income below 133 percent of federal poverty
- Children up to age 19, born after September 30, 1983, in households with income below 100 percent of federal poverty
- Recipients of adoption assistance and foster care under Title IV-E

- "Qualified Medicare Beneficiaries" (QMBs) – individuals who qualify for Medicare Part A, whose incomes do not exceed 100 percent of federal poverty and whose resources do not exceed 200 percent of the SSI resource-eligibility standard

- "Specified Low Income Medicare Beneficiaries" (SLMBs) – individuals who qualify for Medicare Part A, with incomes between 100 and 120 percent of federal poverty and whose resources do not exceed 200 percent of the SSI resource-eligibility standard

- "Qualified Disabled and Working Individuals" – Disabled but employed individuals who qualify for Medicare Part A, with income not in excess of 200 percent of federal poverty and whose resources do not exceed 200 percent of the SSI resource-eligibility standard

In addition to covering all of the mandatory groups, California, extends coverage to a number of "optional" groups. These include:

- Individuals receiving "In-Home Supportive Services" – certain persons who qualify but do not receive SSI, or who have lost this categorical linkage do to substantial gainful activity

- All aged, blind, and disabled individuals who qualify for State supplementary payments but not federal SSI

- Pregnant women and children under age one between 133 and 185 percent of federal poverty

- "Medically Needy" individuals – California, like most (but not all) states, operates a "Medically Needy" program that extends Medi-Cal coverage to other low income persons. To qualify as medically needy in California, an individual must reside in a household with income roughly at 80 percent or less of federal poverty and meet one of the State's additional qualifying criteria, which include: 1) being pregnant or under age 18 and otherwise qualifying as categorically needy if income/resources were lower; or 2) being the caretaker relative of an eligible child; or 3) being aged, blind, or disabled and qualifying as categorically needy if income/resources were lower.

Covered Services

As with eligibility, the Title XIX program includes a series of mandatory and optional services. States may also specify different service packages for their categorically needy and medically needy populations.

California covers a relatively broad scope of services as compared to other states. The only services not covered for categorically needy individuals are: medical social worker

services and private duty nursing. The benefit package for the medically needy population is virtually the same.

California, like many states, does impose limits on the amount of certain services that can be used in a one month or one year period. For example, personal care is limited to 283 hours per month. Therapies, unless ordered for a child through an EPSDT screen, are limited to two sessions per month (across all therapy types).

Expansion under a Waiver

Service expansion under a fully-capitated waiver model is a relatively simple exercise, although somewhat of a misnomer. Some states with fee-for-service benefit limits (or excluded services) have explicitly removed these limits when moving to managed care. The rationale for doing so has been that it is inappropriate to require a health plan to "manage" an enrollee's care while prescribing what services can or cannot be furnished.

More commonly, however, states have not amended their Medicaid State Plans to add services or increase service amounts, but instead have simply instructed health plans to furnish whatever medically necessary services they choose, working within their capitation. This approach has not presented a problem with HCFA and is, in fact, what the San Francisco Health Plan and Blue Cross presumably do today.

It would actually be problematic for San Francisco to seek a change in covered services under California's State Plan (e.g., to add private duty nursing or remove personal care limits), as such a change would apply Statewide. California could only restrict such a change to San Francisco through a 1902(a)(1) waiver of Statewideness granted under Section 1915(b) of the Social Security Act. However, if DHS were to pursue such a waiver on San Francisco's behalf, it would likely result in other counties coming forward to demand similar, special treatment.

With respect to eligibility expansion, San Francisco and DHS are free to propose adding virtually any populations you wish under an 1115a waiver, so long as budget neutrality is maintained. However, as with services, no change could be executed through the State Plan without addressing the Statewideness issue. The key for San Francisco (assuming you pursue an 1115a waiver) will be to make the admittedly difficult case that certain individuals who would be added to the Medi-Cal rolls could have been covered in a portion of the State without the waiver.

Please call me or Cyndy if you have any questions about what is addressed in the memo.

The federal and state governments share Medicaid costs. For program administration costs, the federal government contributes 50 percent for each state. For medical services provided under the program, the federal medical assistance percentage (FMAP), or matching rate, varies among states, ranging from a low of 50 percent to a high of up to 83 percent, based on per capita income (see table 1-1).

States may choose whether to participate in Medicaid, which provides substantial financial incentives to help states cover the costs of health services for people who otherwise cannot pay. Some people lack health insurance altogether, while others need medical services that their insurance plans do not cover. Technically, Arizona is the only state without a Medicaid program, but it operates its own unique managed care program under a special Medicaid demonstration waiver granted in 1982 (see information about waivers in the notebook's section on Managed Care). Arizona's Health Care Cost Containment System receives federal Medicaid matching funds as an alternative medical assistance program for low-income people.

Who Is Eligible for Medicaid?

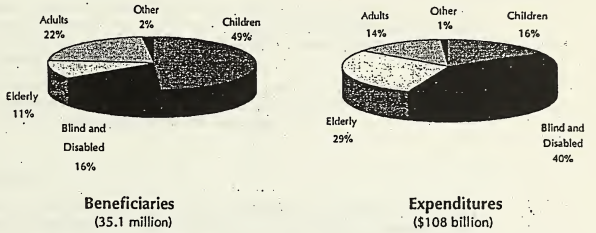
Important Note About AFDC

This section contains references to Aid to Families with Dependent Children (AFDC) and its links to Medicaid eligibility. The welfare reform bill signed by President Clinton on Aug. 22, 1996, ends the AFDC entitlement program and replaces it with block grants to the states. In general, however, people who meet AFDC eligibility criteria that were in effect on July 16, 1996 (which states have some freedom to modify), will be eligible for Medicaid. Accordingly, references to AFDC in this notebook should be read as references to the "frozen" July 16, 1996, AFDC eligibility criteria. For a more detailed discussion of these changes, see the Federal Issues section.

In general, Medicaid covers low-income mothers and children, elderly people who need long-term care services and people with disabilities. Children make up half of the Medicaid population and the elderly, blind and disabled account for 27 percent (figure 1-A). Figure 1-A also illustrates the expenditures for each group; about 16 percent of the Medicaid budget is spent on children, compared with almost 70 percent for the elderly, blind and disabled.

About one-half of Americans with incomes below federal poverty guidelines qualify for Medicaid based on income and "categorical status." Categorical status refers to membership in a certain group, such as people who receive Aid to Families with Dependent Children or Supplemental Security Income (SSI). Men and women who are not elderly and who do not have children or a disability cannot qualify for Medicaid, no matter how poor they are. Although Medicaid eligibility criteria vary among states, federal requirements and options exist for certain populations. States receive the same federal match for providing medical services to the required groups and the optional groups.

Figure 1-A: Medicaid Beneficiaries and Expenditures, 1994



Source: Health Care Financing Administration. "Medicaid National Summary Statistics." (June 1996). URL=http://www.hcfa.gov, World Wide Web.
* Excludes disproportionate share hospital payments and administrative costs.

Mandatory Eligibility

State Medicaid programs must cover the following groups of people, including the key populations of people who receive cash assistance from AFDC or SSI and additional groups of children and pregnant women.

- **People who receive Aid to Families with Dependent Children (AFDC).** Eligibility for AFDC varies widely among states, ranging from a low of 15 percent of federal poverty guidelines (or $1,947 per year for a family of three in 1996) to a high of about 81 percent of poverty (or $10,513 for a family of three in 1996), with a national average of 40.6 percent of poverty (see table 1-2). (Note: See the Federal Issues section for updated information.)
- **People who receive federal Supplemental Security Income (SSI).** Also referred to as the portion of the Medicaid program that serves "aged, blind or disabled" individuals, federal SSI status is based on age, disability and income. (Note: See Federal Issues for updated information.) The following 11 states apply more restrictive standards to their Medicaid eligibility for people who have disabilities, based on standards in place in 1972, before SSI was established: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia. These states are also known as "209(b)" states after the section of the Social Security Amendments of 1972 that established the option.
- **Pregnant women** whose family income is up to 133 percent of federal poverty guidelines for pregnancy-related services, through about 60 days after delivery.
- **Infants born to Medicaid-eligible pregnant women.** Eligibility for such infants must continue throughout the first year of life as long as the infant remains in the mother's household and the mother remains eligible, or would be eligible if she were still pregnant, according to the criteria listed in this section.

- **Children under age 6** whose families earn up to 133 percent of poverty.
- **Older children.** Children born after Sept. 30, 1983, who are over age 5 and live in families with income up to the poverty level. These children, the oldest of whom turned 13 Oct. 1, 1996, are to be phased in each year, through the age of 18.
- **Children who receive adoption assistance or foster care.**
- **Some Medicare recipients.** State Medicaid programs must pay Medicare premiums, deductibles and copayments for elderly and disabled people with incomes below poverty. These groups are known as "qualified Medicare beneficiaries" and "qualified disabled and working individual beneficiaries."
- **Special protected groups.** States must cover certain special groups; for example, they must provide short-term coverage for people who lose AFDC or SSI cash assistance because of increased wages or Social Security payments.

Optional Eligibility

States may choose to cover additional groups under their Medicaid programs, most notably additional children and pregnant women and other people whose medical expenses reduce their income to the state's ceiling to qualify as medically needy. These groups include the following:

- **Infants** whose family income is up to 185 percent of federal poverty guidelines.
- **Pregnant women** with incomes up to 185 percent of poverty guidelines (for pregnancy-related services only.
- **Children** under age 21 who meet certain income and resource requirements under AFDC but who otherwise are not eligible for AFDC. This group consists primarily of youth aged 18 to 21.
- **Certain aged, blind or disabled adults** with incomes below poverty.
- **Certain institutionalized individuals.** This includes people in hospitals, skilled nursing facilities and intermediate care facilities for people with mental retardation or related conditions, who would otherwise be eligible for AFDC or SSI, including those with incomes up to 300 percent of SSI payments. It also includes children under age 18 after 30 days of continuous institutionalization, regardless of parental assets and income.
- **Home- and community-based services waiver recipients.** These individuals must meet both income and medical criteria for institutionalization.
- **Recipients of state supplementary payments.**
- **Low-income people infected with tuberculosis (TB),** for TB services only.
- **"Medically needy" people.** States may set Medicaid income eligibility standards at levels that permit coverage of people who do not qualify for cash assistance, but who meet categorical standards (such as having children, being pregnant or having a disability). These optional income ceilings may not be higher than 133 1/3 percent of the state's AFDC payment. States also have flexibility to provide Medicaid coverage to people who have large medical expenses that consume so much of their resources that they "spend down" to the level that would qualify them for Medicaid.

Table 1-2: Annualized Medicaid Eligibility Thresholds for AFDC, Medically Needy, OBRA Pregnant Women and Infants, August 1996

State	AFDC (Family of 3) Payment[a] Standard	AFDC (Family of 3) Percent of Poverty[c] $12,980	Medically Needy[a] (Family of 3) Allowable Income	Medically Needy[a] (Family of 3) Percent of Poverty[c] $12,980	OBRA Pregnant Women and Infants (Family of 3) Percent of Poverty[c] $12,980
Alabama	$ 1,968	15%	n/a	—	133%
Alaska [d]	12,336	76	n/a	—	133
Arizona	4,164	32	n/a	—	140
Arkansas	2,448	19	$ 3,300	25%	133
California	7,284	56	11,208	86	200
Colorado	5,052	39	n/a	—	133
Connecticut	10,464	81	9,276	71	185
Delaware	4,056	31	n/a	—	185
Florida	3,636	28	3,636	28	185
Georgia	5,088	39	4,500	35	185
Hawaii [d]	8,544	57	8,544	57	300
Idaho	3,804	29	n/a	—	133
Illinois	4,524	35	5,904	45	133
Indiana	3,456	27	n/a	—	150
Iowa	5,112	39	6,792	52	185
Kansas	5,148	40	5,760	44	150
Kentucky	6,312	49	3,696	28	185
Louisiana	2,280	18			133
Maine	6,636	51	5,496	42	185
Maryland	4,476	34	5,208	40	185
Massachusetts	6,780	52	9,300	72	185
Michigan	5,868	45	6,804	52	185
Minnesota	6,384	49	8,508	66	275
Mississippi	4,416	34	n/a	—	185
Missouri	3,504	27	n/a	—	185
Montana	5,258	41	5,964	46	133
Nebraska	4,368	34	5,904	45	133
Nevada	4,176	32	n/a	—	133
New Hampshire	6,600	51	7,824	60	185
New Jersey	5,316	41	6,804	52	185
New Mexico	4,668	36	n/a	—	185
New York [e]	7,884	61	9,800	76	185
North Carolina	6,528	50	4,400	34	185
North Dakota	5,172	40	6,060	47	133
Ohio	4,092	32	n/a	—	133
Oklahoma	3,684	28	5,508	42	150
Oregon	5,520	43	7,356	57	133
Pennsylvania	5,052	39	5,604	43	185
Rhode Island	6,648	51	8,900	69	250
South Carolina	2,400	18	n/a	—	185
South Dakota	6,084	47	n/a	—	133
Tennessee	6,996	54	3,000	23	185
Texas	2,256	17	3,204	25	185
Utah	6,816	53	6,816	53	133
Vermont	7,632	59	10,500	81	[200] [225] [f]
Virginia	2,880	22	4,300	33	133
Washington	6,552	50	8,004	62	[185] [200] [g]
West Virginia	3,108	24	3,480	27	150
Wisconsin	6,204	48	8,268	64	185
Wyoming	7,080	55	n/a	—	133
Average	$ 5,265	40.6%	$ 6,421	49.5%	

Source: National Governors' Association, *MCH Update*, Summer 1996.

* Omnibus Budget Reconciliation Act (see table 3-5 for various OBRA details).
n/a—not applicable

the mentally retarded was added as an optional service under Medicaid in 1971. In 1995, more than $10 billion in Medicaid funds supported ICF/MR services. Since 1971, Medicaid also has become a significant source of community-based funding for people with MR/DD as an alternative to institutional care, ranging from children who live at home, to adults who live in supported apartments or group homes. Every state, except Arizona, has at least one home- and community-based waiver for people with MR/DD.

Mental illness. Although Medicaid covers both acute care and long-term care services for people with mental illness, Medicaid's role in covering residential treatment for mental illness is much more restrictive than coverage for MR/DD services. In 1994, Medicaid provided about $2.9 billion in payments for residential mental health services in "institutions for mental diseases" (IMDs) and psychiatric hospitals. Under federal law, however, Medicaid may not pay for services in IMDs unless the person is age 65 or older or under age 21. Young adults who qualify for Medicaid are not eligible for Medicaid-reimbursed institutional services for mental illness.

Acquired immune deficiency syndrome (AIDS). Medicaid has emerged as the primary source of funding for health care services for people with AIDS, covering 90 percent of children with AIDS. An estimated 60 percent of all AIDS-related spending for health care is covered by Medicaid.

The notebook's sections People with Disabilities/Chronic Conditions and Other Cost Containment Strategies contain additional information on Medicaid services for people with disabilities and chronic conditions.

What Services Does Medicaid Cover?

Medicaid serves as the nation's health insurance plan for poor Americans who meet eligibility requirements. Medicaid has a more comprehensive benefit package than most commercial health insurance plans and Medicare. Medicaid may not exclude people for pre-existing health problems, as many commercial plans do. Most children and adults covered by Medicaid need primary, preventive and acute care services, but others have intensive or chronic health care needs.

Medicaid also serves as the nation's primary source of funding for nursing home care and as a significant funding resource for a wide range of services for people with disabilities who have serious, expensive and long-term health care needs. Therefore, many people who qualify for Medicaid, such as the elderly in nursing homes or middle-income families with children who have severe disabilities, turn to Medicaid as a last resort because their commercial insurance plans do not cover their needed care and they cannot afford the high costs. As with eligibility criteria, Medicaid has both required and optional services.

Required Services

Federal law requires that state Medicaid programs cover the following services:

- Inpatient and outpatient hospital services;
- Physician services;
- Medical and surgical dental services;
- Nursing facility (NF) services for individuals aged 21 or older;
- Home health care for people eligible for nursing facility services;
- Family planning services and supplies;
- Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the state plan;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Federally qualified health center services and any other ambulatory services offered by a federally qualified health center that are otherwise covered under the state plan;
- Nurse-midwife services; and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21, even if the treatment is an optional Medicaid service not otherwise covered in the state's Medicaid plan.

Optional Services

States also may choose to cover certain additional services under their Medicaid plans, except that states must cover any of the optional services if deemed "medically necessary" for a child under EPSDT. This requirement is discussed further in the section Mothers and Children. The most common optional services are clinic services; emergency hospital services; nursing facility services for the aged in an institution for mental diseases; intermediate care facility/mentally retarded (ICF/MR) services; optometrist services and

eyeglasses; prescription drugs; TB-related services for people infected with TB; prosthetic devices; and dental services (nonmedical or surgical).

In addition to the most common optional services listed, states also may choose to cover the following services: services provided by podiatrists, chiropractors and other licensed practitioners recognized by state law, such as nutritionists, dietitians and health counselors; psychological services; private duty nursing; emergency hospital services; personal care services; transportation (although a state must ensure that transportation is available to and from care); case management; hospice services; diagnostic, preventive and rehabilitative services; inpatient psychiatric services; services provided by Christian Science nurses/sanatoria; physical and occupational therapy for speech/language/hearing disorders; services for dentures; and respiratory care services for children who are dependent on a ventilator. Table 1-6 shows which states cover what optional services for their general Medicaid populations.

States also may provide home- and community-based care via waivers under section 1915(c) of the Social Security Act, to certain individuals who are both eligible for Medicaid and eligible for institutional care as a result of their limitations in specified activities of daily living. Covered waiver services may include personal care services, chore services, respite care services, adult day care, homemaker/home health aide, training for family members and nursing services. All states, except Arizona, have such waivers and cover many different population groups. Further information may be found the notebook's section Other Cost Containment Strategies.

Other Services Requirements

Federal law also specifies certain other requirements regarding services, as follows:

- ***Amount, duration and scope.*** Whether they be mandatory or optional, each service must be "sufficient in amount, duration and scope to reasonably achieve its purpose."
- ***Comparability.*** Medicaid services available to any individual in the following groups must be equal in amount, duration and scope for all individuals within the group: (1) categorically needy and (2) a covered medically needy group.
- ***"Statewideness."*** A state's Medicaid plan must be in effect throughout the entire state, so that all recipients have access to similar types and levels of care.
- ***Freedom of choice.*** State Medicaid programs must allow Medicaid recipients to obtain services from any institution, agency, person, pharmacy or organization that qualifies as a Medicaid provider.

States may seek approval for certain exceptions to these service requirements by applying for a waiver from the Health Care Financing Administration (HCFA). For example, HCFA has waived the "freedom of choice" requirement for states to allow them to require that Medicaid recipients enroll in managed care plans (see the notebook's Managed Care section for more information). Demonstration waivers frequently relax the statewideness requirement so that a new concept may be tested in a smaller area, such as in one or two counties.

Table 1-6: Medicaid Services State-by-State

Optional Services in State Medicaid Programs

State	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
Podiatrists' Services			◆	+	+	•	+	•	+	+	+	•	◆	•		•	+	+	+	+	+	+	+	+	◆	•	•
Optometrists' Services	•		◆	+	+	•	+	•	+	+	+	•	◆	•		•	+	+	+	+	+	+	+	+	◆	•	•
Chiropractors' Services				+	+		+			+				•		•	+	+		+	+			+	◆	•	
Psychologists' Services			◆	+	+	•	+						◆			•	+	+			+		+		◆		
Medical Social Workers' Services			◆													•	+				+						
Nurse Anesthetists' Services	•		◆	+	+	•										•	+	+		•		+		+	◆		
Private Duty Nursing			◆	+		•		•	+	+					+	•			•		+	+	+		◆	•	
Clinic Services	•	•	◆	+	+	•	+	•	+	+	+	•	◆	•	+	•	+	+	+	+	+	+	+	+	◆	•	•
Dental Services			◆	+	+		+		+	+	+	•	◆	•		•	+	+	+	+	+	+	+	+	◆	•	•
Physical Therapy		•	◆	+	+		+		+	+	+	•	◆	•	+	•	+	+	+		+	+	+		◆	•	
Occupational Therapy			◆	+	+				+	+	+	•	◆		+	•	+	+	+		+		+		◆	•	
Speech, Hearing and Language Disorders			◆	+	+	•	+		+	+	+	•	◆	•	+	•	+	+	+		+	+	+		◆	•	
Prescribed Drugs	•	•	◆	+	+	•	+	•	+	+	+	•	◆	•	+	•	+	+	+	+	+	+	+	+	◆	•	•
Dentures			◆	+	+		+		+	+	+	•	◆	•			+	+		+	+	+	+	+	◆		•
Prosthetic Devices		•	◆	+	+	•	+	•	+	+	+	•	◆	•	+	•	+	+	+	+	+	+	+	+	◆	•	•
Eyeglasses	•		◆	+	+	•	+		+	+	+	•	◆	•		•	+	+			+	+	+	+	◆	•	•
Diagnostic Services	•	•	◆		+		+	•	+		+		◆		•				+		+	+	+	+	◆	•	
Screening Services	•	•	◆		+		+		+		+		◆		+	•			+		+		+		◆	•	
Preventive Services	•		◆		+		+		+		+		◆			•			+		+		+		◆	•	
Rehabilitative Services	•	•	◆	+	+	•	+	•	+	+	+		◆	•	+	•		+	+	+	+	+	+	+	◆	•	•
Age 65 or Older in IMDs[1] Inpatient Hospital Services		•	◆		+	•	+	•	+	•					+	•	•	+	+	•	+	+	+	+	◆		•
Age 65 or Older in IMDs[1] Nursing Facility Services	•		◆		+	•	+		+					•	+	•		+	+			+	+	+	◆		•
ICF/MR[2] Services	•	•	◆	•	+	•	+	•	+	•	•		◆	•	+	•	•	+	+	•	+	+	+	+	◆	•	•
Inpatient Psychiatric Services for Under Age 21	•	•	◆	+	+	•	+		+				◆	•	+	•	•	+	+	•	+	+	+	+	◆	•	•
Christian Science Nurses			◆		+																+						
Christian Science Sanitoriums			◆		+		+									•			+		+			+	◆		
Nursing Facilities Services for Under Age 21	•	•	◆	•	+	•	+	•	+	•	+	•	◆	•	+	•	•	+	+	+	+	+	+	+	◆	•	•
Emergency Hospital Services			◆	+	+	•		•	+	+		•	◆	•		•		+	+			+	+	+	◆	•	
Personal Care Services		•		•	+			•	+	+				•				+			+	+	+	+	◆		•
Transportation Services		•	◆	+	+	•	+	•	+	+	+	•	◆	•	+	•	+	+	+	+	+		+	+	◆	•	•
Case Management Services	•	•		+	+	•	+		+	•	•		◆	•		•	+	+	+	+	+	+	+	+	◆	•	•
Hospice Care Services	•	•		+	+	•		•	+	+	+		◆	•			+	+	+			+	+	+	◆	•	•
Respiratory Care Services			◆		+					+			◆			•								+	◆		
Tuberculosis-Related Services					+					•	+														◆		
Total Additional Services	15	15	29	24	32	20	24	15	26	24	21	14	24	21	16	30	22	25	24	16	28	22	27	24	32	23	18

Source: U.S. Department of Health and Human Services, Health Care Financing Administration and Division of Intergovernment Affairs, OLIGA, HCFA Publication No. 02155-96, October 1, 1995.

Table 1-6: Medicaid Services State-by-State, cont'd.

Optional Services in State Medicaid Programs

MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	UT	VT	VI	VA	WA	WV	WI	WY	State
+	+		+	+	•		+	+	•	+	◆	+		◆	•	•	◆	+	+	+		+	+	+	+		Podiatrists' Services
+	+	•	+	+	•	+	+	+	•	+	◆	+		◆	•	•	◆	+	+	+		+	+	+	+	•	Optometrists' Services
	+		+	+			+	+	•		◆	+				•		+	+	+				+	+		Chiropractors' Services
+	+		+	+	•	+		+	•						•			+		+		+	•	+	+		Psychologists' Services
+																		+									Medical Social Workers' Services
+	+				•		+		•	+						•		+						+	+	•	Nurse Anesthetists' Services
+	+	•	+			+	+	+	•		◆								+					+	+		Private Duty Nursing
+	+	•	+	+	•	+	+	+	•	+	◆	+	+		•	•	◆	+	+	+	+	+	+	+	+	•	Clinic Services
+	+	•	+	+	•	+	+	+	•	+	◆	•		◆	•	•	◆		+	+	+	+	+	+	+	•	Dental Services
+	+	•	+	+	•	+		+	•		◆				•	•		+	+	+	+	+	+	+	+	•	Physical Therapy
+	+	•	+	+	•	+		+	•		◆				•					+	+	+	+	+	+		Occupational Therapy
+	+	•	+	+	•	+		+	•		◆					•			+	+	+	•	+	+	+	•	Speech, Hearing and Language Disorders
+	+	•	+	+	•	+	+	+	•	+	◆	•	+	◆	•	•	◆	+	+	+	+	+	+	+	+	•	Prescribed Drugs
+	+	•		+	•	+	+	+	•		◆	•		◆		•			+		+		+	+	+		Dentures
+	+	•	+	+	•	+		+	•	+	◆	•		◆	•	•	◆	+	+	+	+	+	+	+	+	•	Prosthetic Devices
+	+	•	+	+	•	+	+	+	•	+	◆	•		◆	•	•		+	+	+	+	+	+	+	+		Eyeglasses
+			+	+		+	+	+	•		◆	•	+					+	+	+	+		•		+		Diagnostic Services
+	+	•	+	+		+	+	+	•	+		•	+						+	+	+					+		Screening Services
+		•	+	+		+	+	+	•		◆	•	+		•				+	+	+		+			+		Preventive Services
+		•	+	+	•	+	+	+	•	+	◆	•	+	◆	•	•	◆	+	+	+	+	+	+			+	•	Rehabilitative Services
+	+	•	+	•		+	+	+		•	◆	+		◆			◆	+	+	+		•	+		+	•	Age 65 or Older in IMDs[1] Inpatient Hospital Services
+	+		+	•	•							+		◆	•	•	◆		+	+		•	+		+		Age 65 or Older in IMDs[1] Nursing Facilities Services
+	+	•	+	•	•	+	+	+	•	•	◆	+		◆	•	•	◆	+	+	+		•	+	+	+	•	ICF/MR[2] Services
+	+		+	•		+	+	+		+	◆	+		◆	•		◆		+	+				+	+		Inpatient Psychiatric Services for Under Age 21
																											Christian Science Nurses
				•							◆							+				+			+		Christian Science Sanitoriums
+	+	•	+	+	•	+	+	+	•	•	◆	+		◆	•	•	◆	+	+	+		+	+	+	+	•	Nursing Facilities Services for Under Age 21
+	+	•	+	+	•	+	+		+	•	◆	+	+		•	•	◆	+	+	+	+	+	+	+	+	•	Emergency Hospital Services
+	+	•	+	+			+	+		•	◆			◆		•		+	+	+			•	+	+		Personal Care Services
+	+	•	+	+	•	+	+	+	•	+	◆	+	+	◆	•	•	◆	+	+	+	+	+	+	+	+	•	Transportation Services
+	•	•	+	+	•	+	+	+	•	+	◆			◆	•	•	◆	+	+	+		+	+	+	+	•	Case Management Services
+			•	•	+	+	+	+	•			+		◆			◆	+	+	+		+	+	+	+	•	Hospice Care Services
		•					+						+				◆	+		+				+	+		Respiratory Care Services
						+				+							◆		+						+	•	Tuberculosis-Related Services
29	25	22	26	28	21	26	23	26	25	18	25	21	9	17	19	20	18	23	27	27	15	21	27	24	33	17	Total Additional Services

Notes:

• = Categorically needy (CN): Individuals receiving federally supported financial assistance.

+ = Both CN and MN (Medically needy: Individuals who are eligible for medical but not for financial assistance.)

◆ = Demonstration: Program operates as a section 1115 demonstration project.

Although states must ensure the availability of necessary transportation, they may seek federal financial participation (FFP) as an optional service and/or administrative cost.

Definitions and limitations on eligibility and services vary from state to state.

Details are available from local welfare offices and state Medicaid agencie.

Services provided only under the Medicare buy-in agreement, EPSDT program, or home- and community-based services waivers are not reflected in this chart..

New Jersey and Texas—services indicated as available to the medically needy are not available to all medically needy groups.

Virgin Islands and Puerto Rico—all services are provided through public health facilities.

[1] IMDs—Institutions for mental diseases.

[2] ICF/MR—Intermediate care facility for the mentally retarded.

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BUDGET NEUTRALITY FOR SECTION 1115 WAIVERS

1. Budget Neutrality Definition and Financing Principles

2. Documenting Budget Neutrality

3. Calculating Budget Neutrality Limit

4. Potential Cost Saving Concepts

BUDGET NEUTRALITY REQUIREMENTS FOR SECTION 1115 WAIVERS

Budget Neutrality Definition

Section 1115 Waiver demonstration projects cannot cost the Federal government more than the Medicaid program would have cost the Federal government absent the Waiver project.

Financing Priniciples That Cannot Be Violated

1. The entire county's Medicaid costs should be included in the budget neutrality calculations and will be subject to the budget neutrality limits.

2. Other Federal cost neutrality limits should not be violated (e.g., the cost neutrality principles in existing California 1915(b) waivers must be honored).

3. Medicaid dollars should not go into "pool-like" mechanisms.

4. Medicaid block grants are not acceptable.

5. The Federal matching rate cannot be changed.

6. OBRA '93 DSH requirements must be satisfied and cannot be modified in any manner.

DOCUMENTING BUDGET NEUTRALITY

- Establish a base year (most recent, complete year)
- Trend or project to estimate how much costs will increase during the term of the project
- Three sets of tables are necessary: one for depicting Medicaid historical costs and eligibility (base year); one for depicting Medicaid projected costs and eligibility assuming that no demonstration is implemented; and one for depicting Medicaid projected costs and eligibility assuming that the demonstration will be implemented.

General Rules to Follow

1. States/County (S/C) should provide all annual expenditure and enrollment information on a Federal fiscal year (FFY) basis. Additional tables may be provided based on State fiscal years (SFY), but may not be substituted for the required FFY tables.

2. S/C must compute expenditure totals on a date of payment basis, comparable to the expenditure totals and categories reported on the HCFA-64. Additional tables on date of service basis (or other) maybe provided, but may not be substituted for those computed on a date of payment basis.

4. Expenditure totals should represent total Medicaid program expenditures broken into the State and Federal shares. Budget neutrality will be determined by Federal share.

5. Program enrollment should be expressed in terms of total enrollee/months, or average monthly eligibility/enrollment.

6. Copies of all statistical tables must be furnished on diskette, using Lotus 1,2,3 (version 2.01 or earlier) files, or a format readily imported into Lotus 1,2,3.

7. DSH projections must be consistent with Public Law 102-234 and OBRA 1993. The S/C must adjust its DSH projections to conform with current law if its DSH program will be affected by these statutes.

8. The "without waiver projections" should include only program components that are already included in the State Plan.

9. States should consult with HCFA while they are developing their financial data to assure that submission of necessary data is in a format that is understandable to the reviewers.

CALCULATING BUDGET NEUTRALITY LIMIT

The historical and projected (both with waiver and without waiver) costs must be broken down into three categories:

1. Medicaid medical services expenditures {this includes SB 1255, Targeted Case Management (TCM), FFS **and** capitation payments received directly from the State or from another service provider/HMO/managed care plan}

2. Disproportionate Share Payments

3. Administrative expenses

SIMPLIFICATION OF METHODOLOGY FOR BASE YEAR CALCULATIONS

Category 1 (Medicaid Medical Services Expenditures)

A. Identify eligibles/aid categories **(ELIGIBLES)** to be included in demonstration

B. Identify costs of services/benefits **(EXPENDITURES)** to be included within the scope of the demonstration.

Step One: Calculate ELIGIBLE months. Multiply B by this number to get base FFS costs.

Step Two : Add SB 1255, TCM, HMO/managed care plan revenues and any other Medicaid dollars (mental health, etc.) to total of Step One.

Grand Total of Step One and Two = Medicaid Medical Services Expenditures

Note: Any services to be excluded from the demonstration must be specifically referenced in both the Benefits section of the proposal and in the Finance/Budget Neutrality section.

Calculating Category 2 and 3 expenses should be straight forward.

METHODOLOGY FOR CALCULATING PROJECTED COSTS

Apply trend factor to Grand Total identified above for both "with waiver" and "without waiver" costs.

POTENTIAL MEDICAID COST SAVINGS CONCEPTS

1. Required enrollment in Two Plan Model managed care plans of Medicaid eligibles with chronic health problems and eligibles who are high users of health services.

2. Implement innovative changes within hospital-based patient care routines and hospital administration to reduce costs and increase inefficiencies (e.g., utilize re-engineering concept that is underway in LA County; solicit ideas from staff).

3. Implement procedures in hospital-based patient care routines to ensure that as patients are discharged and/or released from emergency room, they are linked up with necessary primary care physician (PCP) and scheduled for follow-up visit with a PCP or specialist.

4. Induce voluntary enrollment of remaining Medicaid population into the Two Plan Model managed care plans (e.g., offer increased benefit schedule for optional services; provide limited vouchers for transportation to health care appointments).

5. Implement disease management programs for Medicaid patients with chronic conditions (CHF, asthma, diabetes, hypertension, etc.).

POTENTIAL HEALTH CARE COST SAVINGS CONCEPTS

1. Enrollment in Two Plan Model managed care plans of indigent patients.

2. Enrollment in Two Plan Model managed care plans of indigent patients with chronic health problems.

H. FINANCING ISSUES

General Considerations

HCFA has agreed with the National Governors Association that States can achieve budget neutrality over the life of the project (i.e., 5 years) rather than on a year by year basis.

Although other approaches will be considered, budget neutrality generally has been calculated by comparing the Federal cost under the demonstration to what would have been the Federal cost if there were no demonstration. This requires establishing a base year of costs (usually the last pre-demonstration year) and agreeing to a trending or projection methodology to estimate how much costs would increase. Trending may be tied to a locality based medical care CPI or another method may be used.

Issues which may need to be considered include:

- What would the cost of the program be without the waiver? This may involve:
  - hypothetical program expansions (e.g., groups of eligibles, services, or payments which could have been, but were not previously covered or provided),
  - program terminations (e.g. elimination of the medically needy program)
  - projected managed care savings.
- Should a per capita or aggregate baseline methodology be used?
- What is an acceptable projection methodology?
- Should interim funding limits be imposed?
- Should base year costs be based on actual or projected costs?
- Should budget neutrality be calculated on a cash or accrual basis?
- Should the budget neutrality formula be expressed in terms of the components of the Medicaid program that will be affected by the waiver, or the whole Medicaid program?

Examples of issues to consider:

♦ Budget Neutrality

o Is the proposal budget neutral? Is the baseline estimate for projecting costs of the current plan reasonable? Is the projected growth reasonable? Does the State propose a method of assuring continuing budget neutrality?

o What assumptions does the State use to project costs of the current and proposed waiver program? Do the variables utilized to make the projections have a legitimate basis, e.g., is the price inflation factor a HCFA market basket index, are utilization rate projections based on historical data?

o Has the State factored into its baseline estimates growth trends of enrollment in managed care?

o Are estimated service expenditures reasonable and consistent with documentation available to HCFA?

o Is estimated number of eligibles reasonable based on anticipated outcomes in the proposal and past State experience? Is there an enrollment cap? If so, how does it affect the estimated number of eligibles? How are individuals who will remain eligible under the plan and those who would be eligible under the plan but will be transferred into the waiver considered under an enrollment cap?

o Are estimated administrative expenditures reasonable?

♦ Capitated Rates

o Has the State submitted sufficient data to demonstrate how the State will set capitation rates?

♦ Adequacy and Availability of Funding

o Does the State appear to have the capacity to finance the demonstration?

o How will the State fund its share of the waiver program--program and administrative costs?

o Will local funding be captured? If so, how will the transfers be handled? Is the method reasonable? How will the funding be used?

o Will the State's budget support the waiver project or is additional funding needed? If additional funding is needed, what is the status of securing the funds?

♦ DSH

o Will there be a difference in how disproportionate share hospital (DSH) payments and expenditures are handled?

o How will DSH payments affect estimated cost of the demonstrations?

o Does the State take into account a decline in uncompensated care which result from expanding eligibility and services to a larger population?

♦ Cost Sharing

o Will the State collect premiums or implement other cost-sharing?

- If so, does the State plan to share the premiums or co-payments with HCFA or will they factor them into the rate set for services?

- Are the proposed premiums and cost-sharing reasonable (e.g., are they affordable considering income limitations, are they equitable by gender, age, etc.)?

o Is it clear how premiums and cost sharing levels were derived? Are they adequate?

o Is the State asking for a Federal match for premiums paid by enrollee or employer dollars?

♦ Third-Party Liability (TPL)

o Will the State identify TPL resources for all eligible persons? Has the State requested a waiver of payment of claims requirements related to TPL for persons with TPL? Has such a waiver been requested for those in both managed care and fee-for-service situations?

o How will third-party payments be handled? How will they offset Federal expenditures? Are TPL savings reflected in the capitation rate for managed care plans?

o How will coordination of benefits between third parties and a managed care entity be accomplished?

o Does the State intend not to enroll individuals who have a third party resource into managed care plans?

♦ Impact

o What impact will the demonstration have on total and per capita expenditures?

o What is the impact of the demonstration on Federal versus State costs? Is there an increase or decrease?

Waivers

o Which, if any, sections of the Medicaid statute need to be waived in order for the State to implement its proposed policies and procedures? Has the State requested all of the waivers it needs? Has the State requested waivers that cannot or should not be granted?

INSTRUCTIONS FOR BUDGET NEUTRALITY TABLE SHELLS
August 23, 1996

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Three sets of tables are required: (1) a table of data on past Medicaid expenditures and eligibility; (2) a projection of future Medicaid expenditures and eligibility, assuming the demonstration will be implemented (i.e, a "with waiver" projection); (3) a projection of future Medicaid expenditures and eligibility, assuming that no demonstration is implemented ("without waiver" projection). The accompanying table shells, while designed for reporting past expenditure and eligibility data, should serve as a framework for reporting projected expenditures and eligibles during the proposed demonstration period, with appropriate modifications.

1. General Rules

- States should incorporate their most recent available, applicable and relevant data into historical tables and projections.
- All annual expenditure and eligibility information should be reported on a Federal fiscal year (FFY) basis. States may provide additional tables based on State fiscal years (SFY), but may not substitute SFY tables for the required FFY tables.
- States should compute expenditure totals on a date of service basis.
- Program eligibility should be expressed in terms of total eligible member/months, or average monthly eligibility.
- Without waiver projections should include only program components that are included in the current State Plan. Furthermore, historical data and without waiver projections should include only Title XIX matchable expenditures for Medicaid eligibles; health care programs funded entirely by State and local dollars should not be included.
- Copies of all statistical tables must be furnished on diskette. Microsoft Excel 5.0 is the preferred format.
- *States should consult with HCFA while they are developing their financial data to assure that submission of necessary data is in a format that is understandable to the reviewers.*

2. Specific Worksheets Required

Historical information -- States must provide three categories of historical data: (a) Medicaid medical service expenditures and eligibility, (b) disproportionate share (DSH) payments, and (c) administrative expenses. This information must be provided for the most recent Federal fiscal

year for which complete data are available, and the five preceding years. The data submission should be accompanied by a narrative which lists all data sources, describes the methodology used to compute historical expenditure and eligible/month totals, and points out any weaknesses or shortcomings of the data. HCFA prefers that the historical data be compiled directly from the State's Medicaid claims and eligibility databases. Data derived solely from Medicaid administrative reports, such as Forms HCFA-64 and 2082, are not acceptable.

a. Medicaid program expenditures. States should provide total Medicaid medical service expenditures, along with corresponding eligibility totals. *DSH payments should not be included in these expenditures; they must be reported separately (see below).* States should provide the following break downs:

I. *by basis of eligibility:* up to **nine (9)** unduplicated categories should be reported. (Corresponding lines on Form HCFA-2082 are shown in parentheses.):

- Cash AFDC Adults (2e)
- Non-Cash Recipient Adults (3e, 4e, 5e and 6e)
- Cash AFDC Children (2d)
- Non-Cash Recipient Children (3d, 4d, 5d and 6d)
- SSI Aged (2a)
- Non-Cash Recipient Aged (3a, 4a, 5a and 6a)
- SSI Blind/Disabled (2b and 2c)
- Non-Cash Recipient Blind/Disabled (3b, 3c, 4b, 4c, 5b, 5c, 6b and 6c)
- Other (3f, 4f, 5f and 6f)

ii. *by whether eligibles or service expenditures are to be considered in or out of the demonstration.* The following **three (3)** categories are required:

Eligibles participating in the demonstration

A. Expenditures for services that will be included in the demonstration
B. Expenditures for services that will not be included in the demonstration

Eligibles excluded from the demonstration

C. All expenditures

iii. *by delivery system.* The following **four (4)** categories are required:

- fee-for-service only
- fully-capitated (e.g., HMO, etc.)
- partially-capitated
- primary care case management (PCCM) systems

The breakdowns outlined above are cumulative. For example, a separate expenditure and eligibility total must be reported for "Cash AFDC Adults eligibles who are to be included in the demonstration, and who are enrolled in HMOs," and similarly for all other possible combinations of the three breakdowns. The sum of all expenditure cells across all breakdown categories should equal the total of claims for Medicaid services incurred during the period in question.

b. Disproportionate Share Hospital Payments. *The State must report DSH spending separately,* for the same time period and using the same time frame as used to report medical services expenditures and eligibility. This table should include separate totals for inpatient DSH payments and mental hospital DSH payments. The State should also calculate the proportion of total State Medicaid spending spent on DSH payments for each year.

c. Administrative Expenses. The State should report spending on administrative payments for the most recent year for which complete data are available and the preceding five years.

Projections -- The State should provide both without waiver and with waiver projections for the duration of the demonstration program. The State should provide projections for the same categories as historical data, i.e., (a) Medicaid medical service expenditures and eligibility, (b) DSH payments, and (c) administrative expenses. The State should use the most recent year for which complete data is available as the base for all projections, and may therefore need to project to the first year of the demonstration. A narrative section should also be submitted, which lists the data and describes the methodology used in making the projections.

Without Waiver Projections

a. Medicaid program expenditures
   - The State should project without waiver spending for all eligibility categories included in the current Medicaid program, using the same eligibility categories required for historical data.
   - The State should separately project spending for expansion groups allowable under current law, i.e., 1902(r)(2) eligibles, if applicable.
   - *DSH expenditures should not be reported together with other Medicaid progream expenditures. DSH expenditures must be reported separately (see below).*

b. DSH payments
   - The State should provide spending projections for DSH payments in the absence the demonstration program.
   - Disproportionate Share Hospital (DSH) expenditure projections must be consistent with the annual DSH allotments (P.L. 102-234) and the Omnibus Reconciliation Act of 1993 (OBRA 93) hospital specific limits.

The State must adjust its DSH projections to conform with current law if its DSH program will be affected by these statutes.

c. Administrative expenses
- The State should provide projections of administrative spending in the absence of a demonstration.

With Waiver Projections

a. Medicaid program expenditures
- The State should provide worksheets which project spending for current eligibles who will be included in the demonstration program and new eligibles who will participate in the demonstration. The State should provide projections on current eligibles and new eligibles in separate categories.
- The State should include estimates of eligibility and per member/per month spending for each distinctive eligibility group under the demonstration. That is, if the demonstration will include separate program components with different eligibility rules and benefit packages, projections should be provided for each separate component. Similarly, if the State plans to separate services into different delivery systems, projections should be provided for each service package/delivery system. If these groups differ from the eligibility groups used to report historical expenditure data (see 2.a.i above).

b. DSH payments
- The State should provide projections of any DSH spending that will continue under the demonstration program.
- Disproportionate Share Hospital (DSH) expenditure projections must be consistent with the annual DSH allotments (P.L. 102-234) and the Omnibus Reconciliation Act of 1993 (OBRA 93) hospital specific limits. The State must adjust its DSH projections to conform with current law if its DSH program will be affected by these statutes.
- *DSH expenditures should not be reported together with other Medicaid progream expenditures. DSH expenditures must be reported separately (see below).*

c. Administrative expenses
- The State should provide projections of administrative spending during the demonstration period. Administrative expenses related to the demonstration program should be reported separately.

3. Additional issues to address in the data submission

Adequacy and Availability of Funding

- How will the State share of the waiver demonstration (service and administrative costs) be funded? What is the status of securing the funds?

Cost Sharing

- Will the State collect premiums or implement other cost-sharing?
- If copayments are included as part of the program, how has the State taken the copayment amounts into account in developing the capitation rates?

Third Party Liability (TPL)

- Will Medicaid beneficiaries with TPL be included in the managed care plans? If yes, specify who will have responsibility for pursuing TPL for the managed care enrollees: the managed care plans or the State Medicaid agency?
- How will the State identify TPL resources for all eligible persons? Will they subsequently be adjusted periodically based on the managed care plan's experience?
- How will TPL be collected and by whom, and how will this be tracked? Will payments to plans be reduced to reflect expected TPL recovery?
- Will the State continue to pursue estate and trauma-related recoveries?
- Will the State continue to perform the full range of required TPL activities for those beneficiaries or services not covered under Medicaid managed care plans?
- How will Health Insurance Premium Payment (HIPP) related activities be handled?

Approved Medicaid managed care programs

- If you State has received approval for a Medicaid managed care program under 1915(b) that either has not yet begun, or began recently and is not reflected in the historical data, please include a discussion of savings anticipated from this program.

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

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Eligibles excluded from the demonstration

C. All expenditures

iii. *by delivery system.* The following **four (4)** categories are required:

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TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 5	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 4	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 3	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 2	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 1	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 5	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 4	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 3	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 2	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 1	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles and services included in the demonstration

TE = total expenditure, TMM = total member/months

Base Year	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 5	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 4	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 3	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 2	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
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TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year Minus 1	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
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per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
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TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

TOTAL EXPENDITURES AND ENROLLMENT, BY ELIGIBILITY STATUS AND MANAGED CARE PARTICIPATION
Eligibles included in the demonstration/services excluded from the demonstration

TE = total expenditure, TMM = total member/months

Base Year	Fee-For-Service Only	Fully Capitated	Partially Capitated	PCCM System
AFDC Cash Adults				
TE				
TMM				
per capita (= TE / TMM)				
AFDC Cash Children				
TE				
TMM				
per capita				
Non-Cash Recipient Adults				
TE				
TMM				
per capita				
Non-Cash Recipient Children				
TE				
TMM				
per capita				
SSI Aged				
TE				
TMM				
per capita				
Non-Cash Recipient Aged				
TE				
TMM				
per capita				
SSI Blind/Disabled				
TE				
TMM				
per capita				
Non-Cash Recipient Blind/Disabled				
TE				
TMM				
per capita				
Other				
TE				
TMM				
per capita				
TOTAL (all categories, both adults and children)				
TE				
TMM				
per capita				

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MEDICAID
1115 WAIVER PLANNING COMMITTEE
MINUTES OF MEETING

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Wednesday, September 23, 1998
2:00 - 5:00 p.m.
25 Van Ness Building, Room 330

PRESENT: Merrill Buice (for John Gressman); James Hickman; Mitch Katz, M. D.; Amy Lee; Bruce Livingston; Shahnaz Nikpay; Janet Olsen-Coyle; Nancy Presson; Tony Wagner

GUESTS: Mary Bading (consultant); Andrew Cohen (consultant); George Babcock; Jack Fries; Irwin Hoff; Nathan Nayman; Anthony Nicco; Liz Strand

STAFF: Tangerine Brigham; Richard Hodgson

I. Minutes of August 26, 1998

Janet Olsen-Coyle requested a correction to the summary of her presentation to clarify that the State advocates voluntary managed care enrollment of the Medi-Cal aged, blind and disabled (ABD) as many are dual (Medi-Cal/Medicare) eligibles.

II. Analysis of San Francisco's Medi-Cal Historical Utilization and Costs

Mary Bading and Andrew Cohen presented Pacific Health Policy Group's analysis (attached for members unable to attend) of San Francisco's Medi-Cal utilization and costs for the last three State fiscal years. They noted the following key points as they presented the written report:

1) The report is based on summary data received from the State not actual raw claims data.
2) The analysis annualizes Month of Payment data from two points in time - January and July - of each of the years covered.
3) Average eligibles per month include dual (Medi-Cal/ Medicare) eligibles. The significant decline in 1997 and early 1998 corresponds to the initiation of the Calworks welfare reform program.
4) The analysis shows declining Medi-Cal enrollments in the two managed care plans from May 1997 through April-May 1998 with a slight upswing in June 1998 and a slight decline in July 1998. This trend is consistent with the overall decline in Medi-Cal eligibles.
5) Overall, Temporary Assistance to Needy Families (TANF) and Aged Blind and Disabled (ABD) expenditures over the three years are considered low to average compared to similar jurisdictions.

6) Page 10 - Eligible months, capitation and per member per month (PMPM) costs represent both managed care plans combined.
7) Table 3, - The analysis of Medi-Cal demographics shows that over half the ABD/ SSI population is over age55.
8) Page 12 - Aged, blind and disabled beneficiaries are a very high percent of total compared to other communities in PHPG's database.
9) Page 14 and 15 - "# of users" is actually number of interactions with the health care system; expenditures are State and federal; clinic services include Federally-Qualified Health Centers (FQHCs); and hospital data includes inpatient and outpatient.
10) Expenditures for dental services ($20.84 PMPM) are very high as a percentage of total expenditures for TANF and Medically Needy/ Medically Indigent beneficiaries - this number is significantly above what would be expected and requires further analysis and verification. (The expenditure includes $15 PMPM for restorative care.)
11) Total TANF PMPM costs are very low compared to similar jurisdictions.
12) Page 18 - SSI/ aged eligibles data excludes Medicare; 70% of PMPM is for long term care.
13) In analyzing SSI/ aged eligible months / expenses, tables 5a, 6a and 7a include long term care while 5b, 6b and 7b exclude long term care.
14) Page 22 - San Francisco's SSI/ Blind eligibles are high compared to other jurisdictions; this is believed due to the County's aging demographic. PMPM expenses, conversely, are comparatively low although the pharmacy component is high and bears further investigation.
15) Page 28 - SSI/ Disabled data excludes behavioral health and is, nevertheless, low to average compared other communities in PHPGs database.
16) Page -29 SSI/ Disabled pharmacy expenses are extraordinarily high, this is believed due to the high costs of protease inhibitors for AIDS but bears further investigation to confirm. If it is, it is a relatively fixed cost not amenable to reduction through case management or price negotiation.
17) Page 31 - San Francisco's ratio of Blind/ Disabled to TANF costs is 3.3. PHPG's assessment of a "normal" range of the ratio based on the company's database is 2.5 - 3.0; anything outside that range requires further investigation. TANF costs could be abnormally low or BD costs abnormally high.
18) The very preliminary conclusion of the analysis is that reducing fee-for-service expenditures by 1 to 20% for the blind and disabled aid codes and applying a proxy capitation rate equivalent to the per member per month expenses of the TANF beneficiaries ($84.32), San Francisco could cover 1,171 to 23,415 uninsured with a basic plan equivalent to Medi-Cal. The conclusion is merely an example derived from the methodology and does not represent a recommendation of DPH or the consultants.

The Committee offered the following comments on the presentation:

1. The reduction of Medi-Cal beneficiaries and corresponding reduction in two plan enrollments is likely a function of the improved economy as well as welfare reform.

2. TANF capitation may be low but the 15% administrative fee for managed care would appear to indicate that savings are still possible.
3. There are three savings strategies to consider:
   - Reduce managed care capitation rates;
   - Enroll "phantom eligibles" in managed care - i.e., those eligible for Medi-Cal but not enrolled in the program. There are an estimated 600,000 phantom eligibles in California. (States are generally maximizing enrollments at 75% of eligibles.) Phantom eligibles can be included in a waiver's base;
   - Put Aged, Blind and Disabled (ABD) beneficiaries under managed care/ primary care case management and reduce fee-for -service equivalent expenditures.
4. Some TANF aid codes are not included by the State in the two plan model (estimated 10,000 - 15,000 beneficiaries); also the "enrolled out" are not included. The two plans are working to get them included.
5. One of the most significant reasons that the dollars in the analysis seem low is that Disproportionate Share Hospital (DSH) funding is not included. The "County Hospital" expenditures should be adjusted to include SB 855 and SB 1255 dollars.
6. Hospital outpatient department expenditures could be overlapping with physician/ clinic expenditures. This needs to be investigated further.
7. Of the $20 PMPM for TANF dental expenses, $15 is for restorative care and $5 for diagnostic services. The total still appears very high and bears further investigation - it may be a coding error.
8. The analysis of costs should include long term care (LTC), as the expenses are a significant component of the total. Including LTC in a waiver, however, makes approval much more difficult to obtain. LTC 1115 waivers are approved by a different federal agency and are more research focused. Also, mandatory enrollment in managed care can not be required of Medicare beneficiaries although it can be for Medicaid; this greatly complicates including Medicare/ Medicaid dual eligibles in a single system.
9. Las Vegas has a "social" HMO, which includes dual eligibles. California also has a small dual eligible project. Staff will obtain information on these projects for the Committee.
10. Although all long-term care is under managed care in Arizona, they do not have control of Medicare dollars and, accordingly, there are problems coordinating Medicaid with Medicare spending.
11. Can San Francisco get Medicare savings recognized under a Medicaid 1115 waiver budget neutrality cap even if the Medicare dollars are not controlled by the waiver? Consultant's answer: no, but it could be a political issue under a new administration. Medicare is a middle class oriented program and Medicaid is a poverty program; it is difficult politically to fuse them in any significant way. The previously mentioned Medi/ Medi project in California, however, opens the door for approval of additional projects.
12. Some of San Francisco's disabled are Medi/ Medi and, thus, would be difficult to put under managed care. Staff will research this issue.
13. Other dollars would be saved if waiver savings were used to extend coverage to the uninsured. Those other dollars could be used to extend coverage to additional beneficiaries - thus leveraging the waiver dollars to cover more beneficiaries. This is

an issue for the Mayor to consider vis a vis the entire range of City/ County funding priorities.

14. The Committee noted that feasibility analysis is the emphasis of this planning phase - not policy decisions.

III. Populations for Potential Inclusion in a 1115 Waiver (Continued)

The Services Delivery Subcommittee will be assigned the task of prioritizing populations for potential inclusion in a waiver given the expectation that funding will have limitations.

IV. Committee and Subcommittee Schedules and Workplans Through December 1998

Mr. Hodgson announced the forthcoming meetings of the three Subcommittees. Preliminary reports of the Subcommittees are expected to be made at the October 28 meeting of the full Committee.

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MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, October 28, 1998
2:00 – 5:00 p.m.
25 Van Ness, Room 330

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AGENDA

Item		Process	Time
I.	**Introduction/ Approval of Minutes of September 23, 1998**	Action	2:00 - 2:05pm
II.	**Subcommittee Reports (15 minutes each)**	Information/ Discussion	2:05 - 2:50pm
III.	**Actions Required to the Complete the 1115 Waiver Feasibility Analysis**	Information/ Discussion	2:50 - 4:30pm
IV.	**New Business**		

Background Materials (are being finalized and will be presented at the meeting):

- Committee Minutes of September 23, 1998 See: Minutes
- Waiver Feasibility Analysis Issues/ Subcommittee Recommendations - Summary
- Actions Required to Complete Feasibility Analysis - Summary
- Historical Utilization/ Costs Analysis (for those unable to attend September 23, 1998)

MEDICAID 1115 WAIVER PLANNING
FEASIBILITY ANALYSIS PHASE
I. ISSUES RESOLVED/ SUBCOMMITTEE RECOMMENDATIONS TO DATE

I. ISSUES RESOLVED	RECOMMENDED	JUSTIFICATION	SUBCOMMITTEE/ DATE	COMMENTS
A. Including Aged, Blind and Disabled (ABD) in managed care 1. Explore feasibility of including the disabled population in managed care on a mandatory basis? 2. Should any aid codes be excluded? 3. Should any sub-categories of beneficiaries be exclude because of their current living arrangements or illnesses (e.g., foster care in public placements, seriously mentally ill adults/ emotionally disturbed children, long term care beneficiaries, HIV/ AIDS clients)?	1.Yes, for feasibility analysis only; no implementation recommendation at this time. 2. No, the analysis should include all aid codes but be sensitive to the fact that some subgroups will be less amenable to managed care if current system is perceived as satisfactory. 3. The analysis should emphasize how a "comprehensive, seamless" services delivery system will be achieved - regardless of living arrangements or illness. The analysis should show how the mental health managed care plan serves SMI adults and SED children, and how long term care beneficiaries will be linked in a continuum of care.	1. and 2. The bulk of any potential savings are in the high utilization Aged, Blind and Disabled (ABD) aid codes which are only voluntarily enrolled in managed care. If any significant savings are to be achieved to extend coverage to new client groups (e.g., the uninsured), ABD costs need to be assessed. 3. Although some beneficiaries receiving mental health and substance abuse services are currently in separate specialized provider systems with discrete categorical funding streams, this is not optimal in the long run.	Services Delivery 10/22* Financing and Data 10/19* System Design 10/19* Financing and Data 10/5	Discussions of the feasibility of extending mandatory managed care to the ABD codes must include representatives of the ABD advocacy community The feasibility analysis must be sensitive to the relatively high fixed costs of some ABD services (e.g., protease inhibitors for AIDS patients); savings may be limited by these fixed costs No plan should be implemented which reduces services or access for the ABD population Any waiver feasibility analysis should produce a long-term plan which links all services and ultimately merges categorical funding into a single system.

B. Prioritization of new populations to be included in waiver How should enrollment of the uninsured and other vulnerable populations be prioritized in a waiver?	1. Prioritization should be based on a combination of federal poverty level (FPL) and medical need. 2. A principal goal of the waiver should be to assist in implementation of universal health care in San Francisco. Given the high cost of living here, coverage of individuals to 300% FPL should be considered.	The purpose of the waiver program should be to serve those most in medical need as well as low income, rather than seeking to cover as many low income uninsured as possible. Resources will likely be limited and those available should got to the most in need first. If sufficient dollars are available, coverage at higher income levels should be considered.	Services Delivery 10/22 Services Delivery 10/7	Need to define what constitutes "most in need." Prioritization options include: 1) income as % FPL 2) length of time without insurance 3) families vs. single adults 4) inability to obtain insurance/ pre-existing condition 5) multiple diagnosis/ chronically ill/ difficult to serve
C. Analysis of cost-sharing options Should cost-sharing/ copayment structures be explored for new beneficiaries under a waiver to free-up dollars to cover more clients?	For the feasibility analysis, cost-sharing and copayments at different income levels should be evaluated recognizing that, at very low incomes, any level of cost-sharing discourages participation and blocks access to needed services	A cost-sharing structure could enable the waiver to extend coverage to more beneficiaries with saved/ additional dollars. Coverage could be extended to higher income levels on a sliding fee scale basis.	Services Delivery 10/22	Studies are available showing the impact of cost-sharing at various levels on enrollments and participation. Financing and Data will review this issue in further detail.
D. Increasing the scope of services under managed care Are there services not well represented in the current managed care program that should be added to insure appropriate coverage for the newly added populations	1. Additional services: 1) psychosocial medicine/ substance abuse 2) community-based alternatives to LTC 3) case management 4) rehabilitation services 5) disease management for high care need populations		Services Delivery 10/22 Financing and Data 10/5	Examples of successful case management models: the On Lok; Ryan White case management; AIDS 1915c case management; SFGH ED high users project; and Family Mosaic. Planning should be consumer driven and standards of service.

E. Funding to extend Coverage to the uninsured and vulnerable populations What funding sources are potentially available to extend coverage to new populations under a 1115 waiver? What restrictions exist on these sources which could prevent or limit their application to a waiver program?	Funding sources that should be part of the waiver feasibility analysis are: 1) Existing Title XIX (converted from fee-for-service to capitation) - i.e., the savings under a budget neutrality cap 2) Additional federal funding achieved by getting unmatched public and private charity care expenditures matched 3) Additional State and federal funding achieved by "eligibilizing" beneficiaries who are eligible but not currently enrolled in Medi-Cal		Services Delivery 10/22 Financing and Data 10/19 System Design 10/19	Funding care for the uninsured could be limited by the ability to achieve savings under a waiver program; shortfalls in projected savings could limit enrollments or require dis-enrollments later in the project period. New federal funding could be limited by the "Statewideness" issue - i.e., additional dollars provided to SF to match unmatched funds or eligibilize previously ineligible beneficiaries - could require the State to offer the same funding to all other California jurisdictions
F. Serving high service-utilizing, high cost, high care needs populations How should individuals with intensive high-end care needs be served under the waiver?	Ideally, to achieve a comprehensive, seamless service system, all beneficiaries should be served under a unified system.	High needs populations (e.g., HIV/ AIDS, diabetes, arthritis, etc.) should be served through appropriate case/ disease management protocols with risk-adjusted capitation through the waiver plan to assure that needed health and non-health support services are provided and that payment is linked with level of service.	Services Delivery 10/22 Financing and Data 10/5	More input is needed from groups representing specific high service needs populations Substance abuse services, which are woefully inadequate vis a vis current need, should also be folded into that continuum.

II. ISSUES TO BE RESOLVED/ SUBCOMMITTEE ADDRESSING

II. ISSUES TO BE RESOLVED	SUBCOMMITTEE ADDRESSING	COMMENTS
A. The viability of the "two plan" model/ potential alternatives 1. Do the recommendations made above create the necessary base of covered lives and associated dollars to support the safety net provider infrastructure in San Francisco? 2. If not, are there alternatives to the two plan model that will achieve that goal?	System Design	San Francisco has two different health care delivery systems for Medi-Cal beneficiaries – the 2-plan model and FFS. As a result there is no comprehensive delivery system and inefficiencies result from this model. Our objective should be to improve the overall delivery system. The Subcommittee will continue to review the model and potential alternatives with the following goal in the forefront of discussions: preservation of the essential safety net provider system for needy clients.
B. Are there cultural, linguistic and/ or service distribution barriers to care/ consumer satisfaction? 1.Are there barriers to care/ consumer satisfaction in the current managed care two plan model? 2. Are there barriers to care/ consumer satisfaction in Medi-Cal fee-for-service? 3. Are there barriers to care for the uninsured that can be addressed through a 1115 waiver?	Services Delivery	Data is sill being collected to address these questions.

* Proposed recommendations from these meetings are excerpted from the draft minutes which have not yet been approved by the Subcommittees. The approved minutes of previous meetings are attached.

MEDICAID 1115 WAIVER PLANNING
SERVICES DELIVERY SUBCOMMITTEE MEETING

October 7, 1998
11:00a.m. – 12:30p.m.
101 Grove Street, Room 204E

MINUTES

PRESENT: Merrill Buice (guest); Jeanne Finberg; Richard Gibbs, M.D.; Richard Hodgson (staff); Bruce Livingston; Mary Wong

1. Introduction/ Minutes of August 5, 1998

Minutes of August 5, 1998 approved as submitted.

2. Guiding Principles

Guiding principles finalized at the September 23, 1998 full Committee meeting were distributed as information.

3. Highlights of the Analysis of San Francisco's Historical Utilization and Costs/ Waiver Financing Strategies

As background for its discussion of populations for potential inclusion in a waiver, Richard Hodgson presented highlights of Pacific health Policy Group's analysis of San Francisco's Medi-Cal utilization and cost data for the last three State fiscal years. The key points presented are summarized below:

1) The analysis annualizes Month of Payment data from two points in time - January and July - of each of the years covered.

2) The analysis shows declining Medi-Cal enrollments in the two managed care plans from May 1997 through April-May 1998 with a slight upswing in June 1998 and a slight decline in July 1998. This trend is believed to be the result of welfare reform and an improved economy resulting in an overall decline in Medi-Cal eligibles.

3) Overall Temporary Assistance to Needy Families (TANF) and Aged Blind and Disabled (ABD) expenditures over the three years are considered low to average compared to similar jurisdictions.

4) Expenditures for dental services are very high as a percentage of total expenditures for TANF beneficiaries - this number is significantly above what would be expected and requires further analysis and verification.

5) Another category in which expenditures are outside the range of comparable jurisdictions is pharmacy for the Disabled; this is believed to reflect the expenses of multi-drug therapy for AIDS patients but, again, requires further analysis and verification.

6) The very preliminary conclusion of the analysis is that reducing fee-for-service expenditures by 1 to 20% for the blind and disabled aid codes and applying a proxy capitation rate equivalent to the per member per month expenses of the TANF beneficiaries ($84.32), San Francisco could cover 1,171 to 23,415 uninsured with a basic plan equivalent to Medi-Cal. The conclusion is merely an example derived from the methodology and is not a recommendation of either the consultant or DPH; more analysis of the data is needed to draw viable conclusions

Mr. Hodgson continued by summarizing the four basic strategies San Francisco could pursue (singly or in combination) in a Medicaid 1115 waiver:

1) Improve services to existing Medi-Cal beneficiaries with savings as a secondary goal;
2) Seek to achieve savings to extend health care coverage to the uninsured and other vulnerable populations;
3) Get unmatched charity care expenditures (public and private) federally matched; and
4) "Eligibilize" current non-Medi-Cal clients and get the expenditures federally matched.

The Subcommittee offered the following comments on these presentations:

1) New York nationally and Los Angeles on the State level opened the door to pursue strategies to substantially increase federal Medicaid dollars through an 1115 waiver and to eligible clients not previously on Medi-Cal. With L.A.'s example, S. F. should not be hindered by "Statewideness" concerns.
2) If San Francisco intends to propose extending managed care/ primary care case management to the Medi-Cal aged blind and disabled (ABD) on a mandatory basis, the ABD advocacy community must first be consulted.
3) Case management is not the only answer for improving Medi-Cal services; other service delivery change options should also be evaluated.
4) The four aforementioned waiver strategies must be brought together with the potential populations to be covered into a coherent, compelling argument for proceeding with the waiver.
5) A principal goal of the waiver should be to assist in implementing Universal Health Care in San Francisco. In addition to waiver savings and new dollars, other funds will likely be required to cover the estimated uninsured and other vulnerable populations. San Francisco should consider covering the uninsured to 300% of Federal Poverty Level (FPL).
6) The provider community is interested in a waiver application that seeks new federal dollars; a program that only seeks to squeeze more savings out of already meager reimbursement is not a desirable program.

4. "Populations for Potential Inclusion" - Policy Paper Outline

Mr. Hodgson presented a draft outline of a policy paper to be prepared for the discussion by this Subcommittee. The paper will seek to frame the issues and assist the Subcommittee in its deliberations and prioritization of the populations being proposed for what could be limited waiver funding. The Subcommittee's discussion focused on a recent State-sponsored external quality review organization (EQRO) study of Medi-Cal managed care. The study reviewed pediatric preventive care, prenatal care and quality improvement services for two Local Initiatives, two County-Organized Health Systems (COHSs) and four Geographic Managed Care plans in California. The study was critical of these plans citing them primarily for deficiencies in medical record keeping. The study's methodology was criticized and was revised for the second round of reviews (which included the San Francisco Health Plan). Mr. Hodgson will provide copies of the study at the next meeting as well as the SFHP review when it becomes available.

The Subcommittee approved proceeding with the policy paper development based on the outline.

5. Chair Selection/ Reporting to the Full Committee

Bruce Livingston was selected chair of the Subcommittee. Mr. Hodgson will coordinate with Mr. Livingston regarding reporting on the Subcommittee's deliberations to the full Committee on October 28 and at future meetings.

6. Subcommittee Schedule

The October 16 meeting was rescheduled to October 22, 1998; 11:00am - 12:30pm; 101 Grove Street; Room 302.

MEDICAID 1115 WAIVER PLANNING FINANCING AND DATA SUBCOMMITTEE

October 5, 1998
3:00 - 4:30pm
101 Grove Street, Room 302

MINUTES OF MEETING

PRESENT: Mary Bading (by conference call); Merrill Buice (for John Gressman); Richard Hodgson; David Ishida; Amy Lee; Monique Zmuda

I. Minutes of August 3, 1998/ Guiding Principles

Minutes of August 3 approved as submitted. Finalized guiding principles were distributed as information.

II. Analysis of San Francisco's Medi-Cal historical Utilization and Costs - Highlights

Mary Bading and Richard Hodgson reported on the highlights of Pacific Health Policy Group's analysis of San Francisco's Medi-Cal utilization and costs for the last three State fiscal years. The analysis was previously presented in great detail at the full Waiver Planning Committee meeting of September 23 at which several members of this Subcommittee were in attendance; accordingly, this presentation covered only the key points. Ms. Bading noted the following highlights:

1) The analysis annualizes Month of Payment data from two points in time - January and July - of each of the years covered.

2) The analysis shows declining Medi-Cal enrollments in the two managed care plans from May 1997 through April-May 1998 with a slight upswing in June 1998 and a slight decline in July 1998. This trend is believed to be the result of welfare reform and an improved economy resulting in an overall decline in Medi-Cal eligibles.

3) Overall Temporary Assistance to Needy Families (TANF) and Aged Blind and Disabled (ABD) expenditures over the three years are considered low to average compared to similar jurisdictions.

4) Expenditures for dental services are very high as a percentage of total expenditures for TANF beneficiaries - this number is significantly above what would be expected and requires further analysis and verification.

5) Another category in which expenditures are outside the range of comparable jurisdictions is pharmacy for the Disabled; this is believed to reflect the expenses of multi-drug therapy for AIDS patients but, again, requires further analysis and verification.

6) The very preliminary conclusion of the analysis is that reducing fee-for-service expenditures by 1 to 20% for the blind and disabled aid codes and applying a proxy capitation rate equivalent to the per member per month expenses of the TANF beneficiaries ($84.32), San Francisco could cover 1,171 to 23,415 uninsured with a basic plan equivalent to Medi-Cal. The conclusion is merely an example derived from the methodology and is not a recommendation of either the consultant or DPH; more analysis of the data is needed to draw viable conclusions

The Subcommittee raised the following questions and issues regarding the analysis:

1) Expenditures for the 55+ and 65+ age categories need to be broken out and their utilization and costs analyzed in further detail. There has been no final decision by the full Committee that the aged will be included or not included in a 1115 waiver proposal; accordingly, their costs need to be identified and analyzed.

2) The analysis reflects total **reimbursement** provided by Medi-Cal - not the total costs of providing services; costs exceed reimbursement for DPH and must be subsidized from other funding sources.

3) The dental expenditures for TANF particularly as a percent of total appear to be out of line with the Medi-Cal Annual Statistical Report and other information on San Francisco's Medi-Cal expenses. Although they may reflect dental school billing for restorative procedures, they still appear abnormally high and may be a reporting error or total expenditures may be missing some categories. This bears thorough investigation before any conclusions can be drawn from the data. Previous years should be looked at also to see if there is a trend.

4) In establishing the budget neutrality baseline, Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) should be projected high to reflect DPH's status as a significant disproportionate share provider.

5) The financial analysis associated with the 1115 waiver feasibility study should include **all** Medi-Cal expenditure categories - including mental health, long term care, substance abuse, etc. No decisions have yet been made regarding what services and funding streams will be incorporated into a waiver proposal; accordingly, all services and dollars should be analyzed before any conclusions are drawn regarding what should be included/ carved out.

6) Related to 5), a stated guiding principle of the waiver planning process is to develop a "comprehensive, seamless" health care delivery system. This requires looking at all services and funding sources with an eye toward simplifying and standardizing linkages between services, providing universal access and reducing duplicative eligibility and intake processes.

7) The waiver planning process needs to be focused on the health care consumer and to identify minimum standards of service that a comprehensive, coordinated health care system should be required to address. The goal should be to improve the service delivery system with the generation of savings as a secondary goal. The planning process should be systematic in its approach and aimed at eliminating fiefdoms of specialized services and categorical funding. Reporting and control functions should be standardized so that components of the system can be compared on utilization, outcomes and costs.

III. Waiver Financing Strategies

Due to insufficient time remaining, the discussion of optional waiver financing strategies was deferred to the next meeting.

IV. Chair Selection/ Reporting to the Full Committee

The Subcommittee selected Amy Lee as its Chair. Reporting to the full Committee will also be further discussed at the next meeting.

V. Subcommittee Schedule/ Next Meeting

The Subcommittee schedule will remain as indicated in the handout attached to this agenda until further notice. The next meeting will be:

October 19, 1998
3:00 -4:30pm
101 Grove Street, Room 302

MEDICAID 1115 WAIVER PLANNING SYSTEM DESIGN SUBCOMMITTEE

September 29, 1998
1:30 - 3:00pm
101 Grove Street, Room 302

MINUTES OF MEETING
(Revised to incorporate comments at 10/19 meeting)

PRESENT: Jack Fries; James Hickman; Irwin Hoff; Marie Jobling; Michael Keys; Shahnaz Nikpay

GUEST: George Babcock; Merrill Buice

STAFF: Dick Hodgson

I. Minutes of July 20,1998

Approved as submitted

II. Guiding Principles

Guiding Principles finalized at the September 23 meeting of the full Committee were distributed as information.

III. Outline of Policy Paper - The Two Plan Model and Potential Alternatives

Mr. Hodgson presented a draft outline of a policy paper to be prepared for the Subcommittee's review and discussion on the issues suurounding San Francisco's Medi-Cal managed care Two Plan model and potential alternatives. The Subcommittee raised the following questions and issues regarding the draft outline:

1) The goal of the policy paper should be to identify the strengths and weaknesses of the two plan model specifically for San Francisco.
2) Why was the two plan (as opposed to a single plan) instituted in California? Answer; to provide plan choice to consumers as well as provider choice. In the planning phase, twelve counties had sufficient potential Medi-Cal enrollments in the State's view to initiate two competing plans. San Francisco's potential enrollments were initially estimated as higher than were actually available when the two plans started up. This was most likely due to several factors including welfare reform and an improved economy reducing Medi-Cal beneficiaries, plus the long lead time between the enrollment estimating and plan implementation.
3) A significant deficiency of the two plan model is that it diverts needed Medi-Cal dollars from public safety net services into duplicate plan administrations and private company profits. This threatens the long term financial viability of essential safety net providers. A public safety net will always be required to provide services to those San Francisco residents who are in need of health services but have no insurance

coverage or other means of paying. Accordingly, a public safety net system needs to be in place and funds need to be available from a variety of sources (including Medi-Cal) to assure a financial base to maintain the system.

4) The paper must be clear that there are distinctions between the two plans and that the criteria for determination of the viability of each will be different. One plan (Californiacare) has a Statewide enrollment base and administrative structure; Accordingly, the level of San Francisco enrollments it requires for financial viability may be less than the Local Initiative (San Francisco Health Plan) whose potential enrollment base is limited to San Francisco County.
5) The question that the policy paper should address is: What model will assure preservation and long term viability of essential public safety net services? This question is more important for the waiver feasibility analysis/ planning process than what critical mass of enrollments is needed for each plan to attain and maintain long term financial viability.
6) Another significant issue the policy paper should address is: The duplicative administrative structures/ costs (15% of total) of the two plans drain off dollars that could be spent on patient care services. For this reason, many physicians and hospitals are dissatisfied with the two plan model.
7) Two plans offering essentially the same benefits (there are some minor differences) and utilizing essentially the same provider network does not represent significant consumer choice, nor does it improve access to providers.
8) The principal difference between the two plans is that one (SFHP) primarily capitates physician services while the other (Californiacare) primarily pays physicians on a fee-for-service basis. This is a distinction that is invisible to consumers and there is no evidence it impacts access to services or quality of care.
9) "Eligibilizing" uninsured indigents and identifying funding for their care under a 1115 waiver could increase enrollment bases for the two plans into ranges consistent with achieving the State-sanctioned minimums necessary for achieving long term viability. If the same provider network is used by both, however, significantly increased enrollments could strain provider capacity. Additional dollars obtained through a waiver might be better spent increasing that provider capacity than in supporting the two plans administrative overhead.

IV. Chair Selection/ Reporting to the Full Committee

Jack Fries was selected by the Subcommittee to serve as its chair. His principal responsibility in that capacity will be reporting findings and recommendations to the full Committee.

IV. Subcommittee Schedule - No change from the schedule attached to the agenda

October 19, 1998

SAN FRANCISCO'S MEDI-CAL MANAGED CARE TWO PLAN MODEL - STRENGTHS AND WEAKNESSES

STRENGTHS	WEAKNESSES
1) Engenders competition which could result in improved cost efficiency and service quality	1) Duplicate administrative structures/ costs reduce total dollars available for patient care services
2) Provides consumers with plan choice and an option to change if dissatisfied with current plan	2) Diverts Medi-Cal dollars needed to support safety net and subsidize indigent care to private providers with low or no indigent care volumes
3) Providers have options for receiving reimbursement - fee-for-service or capitation - under different provider/ plan risk-sharing models	3) Creates duplicate administrative structures for the same benefits package and provider network
4) Commercial plan has better access to capital and administrative support as part of a statewide organization	4) The number of Medi-Cal beneficiaries (potential two plan enrollees) is below the State's viability threshold (45,000) for two plans and the trend in eligibles is downward
5) Commercial plan has more experience in marketing and competing for clients	5) Total potential Medi-Cal enrollees (as of July 1998) were only 4,015 above the minimum enrollment level specified for Local Initiative plan viability
6) Local initiative was locally-created and is locally-administered; closer to local consumer, community and provider interests	
7) Local initiative strongly supports the public and non-profit safety net system which must be preserved as the provider of last resort for the uninsured and other vulnerable populations	

City and County of San Francisco
Presentation to Waiver Planning Committee

Profile of Waiver-Eligible Populations in the Fee-for-Service Program

September 23, 1998

THE PACIFIC HEALTH POLICY GROUP

PROFILE OF WAIVER-ELIGIBLE POPULATIONS
PURPOSE AND METHOD

PURPOSE

- Determine the number of potential TANF and SSI (blind and disabled) Medicaid eligibles potentially available for inclusion in an 1115a research and demonstration waiver
- Quantify the average monthly fee-for-service costs of the potential waiver populations
- Identify areas (service categories) with relatively high and low costs, as compared to other counties in California and to other states
- Estimate--at an "order of magnitude"--whether a waiver program would produce sufficient savings to provide coverage to meaningful numbers of the uninsured

PROFILE OF WAIVER-ELIGIBLE POPULATIONS
PURPOSE AND METHOD

METHOD

- Data Sources:
  - Eligible counts: CDHS January/July eligible reports for SFY 1995 - 1997
  - Expenditures: CDHS summary claims file for CY1997
  - Managed care data: CDHS managed care payment summary report for San Francisco
  - Other states: PHPG data library (Alabama, Arizona, New York, Vermont)
- Detailed expenditure reports produced by aid category, showing units of service, expenditures, average cost per unit, units per eligible per month, and average cost per eligible per month (PEPM/PMPM)
- Summary reports produced grouping expenditure line items into broader categories

PROFILE OF WAIVER-ELIGIBLE POPULATIONS
TABLES

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1 Average Eligibles per Month, by Aid Category

2 Total Eligible Months - 1995 to 1998
By Aid Category
By Managed Care Plan

3 FFS Population Demographics

4 TANF Summary Expenditures Under FFS - CY1997
Including Medically Needy
Excluding Medically Needy

5 Aged, Blind Summary Expenditures Under FFS - CY 1997
Including Long Term Care
Excluding Long Term Care

PROFILE OF WAIVER-ELIGIBLE POPULATIONS
TABLES

6 Blind Summary Expenditures Under FFS - CY 1997
Including Long Term Care
Excluding Long Term Care

7 Disabled Summary Expenditures Under FFS - CY 1997
Including Long Term Care
Excluding Long Term Care

8 Cost Summary by Aid Category

9 TANF/SSI Costs - Comparison to Other States

10 "Order of Magnitude" Estimate of Dollars Available to Cover the Uninsured

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 1
Traditional Medicaid Eligibles - Average Number of Eligibles per Month
State Fiscal Years 1995 - 1997

	State Fiscal Year				
Aid Category	SFY 1995	SFY 1996	SFY 1997	Avg. Ann. Pct. Change	Total Pct. Change
TANF					
Adults	11,917	11,191	9,468	-10.9%	-20.6%
Children	23,073	20,819	16,776	-14.7%	-27.3%
Sub-Total	34,990	32,010	26,243	-13.4%	-25.0%
ABD/SSI					
Adults	53,288	54,358	54,135	0.8%	1.6%
Children	1,492	1,577	1,521	1.0%	1.9%
Sub-Total	54,780	55,934	55,656	0.8%	1.6%
Combined					
Adults	65,204	65,549	63,603	-1.2%	-2.5%
Children	24,565	22,395	18,296	-13.7%	-25.5%
GRAND TOTAL	89,769	87,944	81,899	-4.5%	-8.8%

Notes:
1 Numbers based on reported eligibles in January and July of each year, divided by two
2 Children includes eligibles through age 18; adults includes eligibles ages 19+

Source: California Department of Health Services

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 2-a
Traditional Medicaid Eligibles - Eligible Month Trend (Total)
State Fiscal Years 1995 - 1997

Aid Category	State Fiscal Year			Avg. Ann. Pct. Change	Total Pct. Change
	SFY 1995	SFY 1996	SFY 1997		
TANF					
Adults	142,998	134,292	113,610	-10.9%	-20.6%
Children	276,876	249,822	201,306	-14.7%	-27.3%
Sub-Total	419,874	384,114	314,916	-13.4%	-25.0%
ABD/SSI					
Adults	639,450	652,290	649,620	0.8%	1.6%
Children	17,904	18,918	18,246	1.0%	1.9%
Sub-Total	657,354	671,208	667,866	0.8%	1.6%
Combined					
Adults	782,448	786,582	763,230	-1.2%	-2.5%
Children	294,780	268,740	219,552	-13.7%	-25.5%
GRAND TOTAL	1,077,228	1,055,322	982,782	-4.5%	-8.8%

Notes:
1 Numbers based on reported eligibles in January and July of each year, multiplied by six
2 Children includes eligibles through age 18; adults includes eligibles ages 19+

Source: California Department of Health Services

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 2-b
Managed Care Eligible Month Trend
1996 - 1998

	SF Health Authority					CaliforniaCare					Total		
	PA	MN	MI	Total	Cap Pmt	PA	MN	MI	Total	Cap Pmt	PA	MN	MI
July - Dec, 1996	-	-	-	-	$ -	9,247	3,423	1,257	13,927	$ 1,147,702	9,247	3,423	1,257
Jan - June, 1997	71,381	16,035	6,033	93,449	8,642,905	62,303	14,576	5,378	82,257	6,872,043	133,684	30,611	11,411
July - Dec, 1997	100,624	23,075	8,041	131,740	12,924,738	70,806	15,134	4,537	90,477	7,572,461	171,430	38,209	12,578
Jan - June, 1998	93,198	20,808	6,781	120,787	11,838,175	66,481	13,553	3,640	83,674	7,026,165	159,679	34,361	10,421

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Traditional Medicaid Eligibles - Managed Care Eligible Month Trend
State Fiscal Years 1995 - 1997

	SF Health Authority					CaliforniaCare			
	PA	MN	MI	Total	Cap Pmt	PA	MN	MI	Total
1996									
July				-		34	11	-	45
August				-		352	90	57	499
September				-		513	164	71	748
October				-		816	274	106	1,196
November				-		2,698	1,207	426	4,331
December				-		4,834	1,677	597	7,108
				-		9,247	3,423	1,257	13,927
1997				-					-
January	878	151	47	1,076	94,740	6,013	1,960	773	8,746
February	3,541	686	261	4,488	416,456	7,383	1,881	715	9,979
March	13,401	2,844	1,145	17,390	1,481,608	11,318	2,531	975	14,824
April	17,115	4,023	1,574	22,712	1,953,312	12,545	2,852	1,086	16,483
May	18,297	4,144	1,517	23,958	2,356,940	12,579	2,680	931	16,190
June	18,149	4,187	1,489	23,825	2,339,849	12,465	2,672	898	16,035
July	17,831	3,952	1,472	23,255	2,287,595	12,273	2,636	852	15,761
August	17,415	3,938	1,422	22,775	2,242,831	12,127	2,624	796	15,547
September	16,863	3,931	1,398	22,192	2,174,522	11,838	2,561	764	15,163
October	16,535	3,892	1,295	21,722	2,125,988	11,706	2,498	757	14,961
November	16,171	3,695	1,271	21,137	2,069,393	11,500	2,442	714	14,656
December	15,809	3,667	1,183	20,659	2,024,409	11,362	2,373	654	14,389
	172,005	39,110	14,074	225,189	21,567,643	133,109	29,710	9,915	172,734
1998									
January	15,557	3,412	1,147	20,116	1,971,104	11,185	2,314	609	14,108
February	15,219	3,382	1,060	19,661	1,932,278	11,017	2,232	572	13,821
March	15,140	3,464	1,098	19,702	1,933,726	11,018	2,219	593	13,830
April	15,253	3,324	1,042	19,619	1,928,944	10,886	2,153	581	13,620
May	15,524	3,547	1,156	20,227	1,981,850	11,079	2,267	621	13,967
June	16,505	3,679	1,278	21,462	2,090,273	11,296	2,368	664	14,328
July	16,526	3,579	1,223	21,328	2,077,923	11,338	2,259	608	14,205
	109,724	24,387	8,004	142,115	13,916,098	77,819	15,812	4,248	97,879

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Traditional Medicaid Eligibles - Managed Care Eligible Month Trend
State Fiscal Years 1995 - 1997

	Total						
Cap Pmt	PA	MN	MI	Total			
4,716	34	11	-	45			
42,817	352	90	57	499			
67,763	513	164	71	748			
106,738	816	274	106	1,196			
344,779	2,698	1,207	426	4,331			
580,889	4,834	1,677	597	7,108	Months		13,927
1,147,702	9,247	3,423	1,257	13,927	Capitation	$	1,147,702
					PMPM	$	82.41
718,137	6,891	2,111	820	9,822			
830,716	10,924	2,567	976	14,467			
1,244,796	24,719	5,375	2,120	32,214			
1,378,783	29,660	6,875	2,660	39,195			
1,357,893	30,876	6,824	2,448	40,148			
1,341,718	30,614	6,859	2,387	39,860			
1,317,546	30,104	6,588	2,324	39,016			
1,301,419	29,542	6,562	2,218	38,322			
1,272,108	28,701	6,492	2,162	37,355			
1,249,412	28,241	6,390	2,052	36,683			
1,225,441	27,671	6,137	1,985	35,793			
1,206,535	27,171	6,040	1,837	35,048	Months		397,923
14,444,504	305,114	68,820	23,989	397,923	Capitation	$	36,012,147
					PMPM	$	90.50
1,183,611	26,742	5,726	1,756	34,224			
1,163,438	26,236	5,614	1,632	33,482			
1,162,222	26,158	5,683	1,691	33,532			
1,145,571	26,139	5,477	1,623	33,239			
1,172,544	26,603	5,814	1,777	34,194			
1,198,779	27,801	6,047	1,942	35,790			
1,190,781	27,864	5,838	1,831	35,533	Months		239,994
8,216,946	187,543	40,199	12,252	239,994	Capitation	$	22,133,044
					PMPM	$	92.22

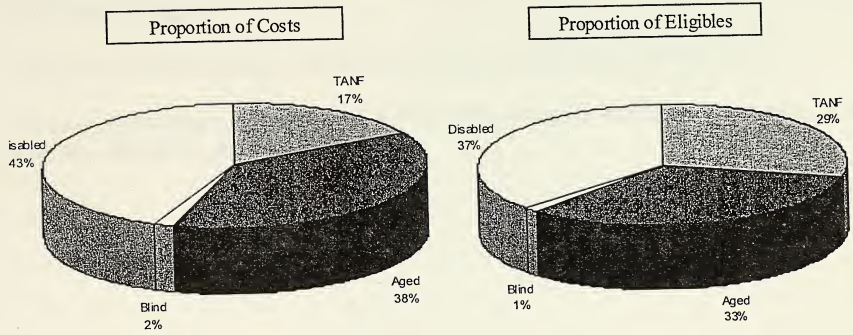
City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 3
Fee-for-Service Population Demographics
State Fiscal Year 1997

Age Range	Eligibles	Eligible Months	Percent of Total
TANF			
Less than Age One	920	11,034	3.5%
1 to 6	6,434	77,208	24.5%
7 to 13	5,976	71,706	22.8%
14 to 18	3,052	36,618	11.6%
19 to 34	4,612	55,338	17.6%
35 to 44	3,570	42,840	13.6%
45 to 54	1,436	17,232	5.5%
55 and Over	245	2,940	0.9%
Total	26,243	314,916	100.0%
ABD/SSI			
Less than Age One	30	354	0.1%
1 to 6	319	3,822	0.6%
7 to 13	552	6,624	1.0%
14 to 18	425	5,100	0.8%
19 to 34	3,905	46,860	7.0%
35 to 44	6,590	79,074	11.8%
45 to 54	6,705	80,454	12.0%
55 and Over	37,132	445,578	66.7%
Total	55,656	667,866	100.0%
GRAND TOTAL	81,899	982,782	

Source: California Department of Health Services

Comparison of Eligibles to Costs



PROFILE OF WAIVER-ELIGIBLE POPULATIONS

Eligibles Trend - Comments

- Enrollment of the TANF population appears to be complete. The only potential dollars available for an eligibility expansion would be those obtained through a reduction in health plan capitation rates.
- The SSI population includes a higher than average number of aged beneficiaries.
- The growth/shrinkage rates for TANF and SSI area consistent with those observed in other programs throughout the country.

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 4-a
TANF Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service)
Calendar Year 1997

POPULATION

Eligible Months	203,136
Average Eligibles per Month	16,928

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	93,138	544,860	$ 17,128,400	$31.44	2.68	$84.32	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	208	208	$ 5,762	$ 27.70	0.00	$ 0.03	0.0%
Other Office Visits (non-OB)	13,056	16,822	$ 357,864	$ 21.27	0.08	$ 1.76	2.1%
Prenatal Care	345	958	$ 46,333	$ 48.36	0.00	$ 0.23	0.3%
Emergency Room	2,933	3,203	$ 74,918	$ 23.39	0.02	$ 0.37	0.4%
All Other	5,044	37,708	$ 1,014,082	$ 27.70	0.19	$ 4.99	5.9%
Sub-Total Physicians	21,586	58,899	$ 1,498,959	$ 25.45	0.29	$ 7.38	8.8%
Clinic Services (including RHCs)	11,307	18,505	$ 2,325,795	$ 125.68	0.09	$ 11.45	13.6%
Behavioral Health							
Psychiatry	600	2,030	$ 46,233	$ 22.78	0.01	$ 0.23	0.3%
Psychology	1,054	3,712	$ 125,919	$ 33.92	0.02	$ 0.62	0.7%
Sub-Total Behavioral	1,654	5,742	$ 172,153	$ 56.70	0.03	$ 0.85	1.0%

Table 4-a

TANF Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service)

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Pct of Total
Community Hospital Services							
Inpatient	650	3,088	$ 3,635,385	$ 1,177.26	0.02	$ 17.90	21.2%
Outpatient	13,873	59,640	$ 1,120,014	$ 18.78	0.29	$ 5.51	6.5%
Sub-Total Community Hospital	14,523	62,728	$ 4,755,399	$ 75.81	0.31	$ 23.41	27.8%
County Hospital Services							
Inpatient	343	1,642	$ 1,361,129	$ 828.95	0.01	$ 6.70	7.9%
Outpatient	2,661	10,961	$ 182,270	$ 16.63	0.05	$ 0.90	1.1%
Sub-Total County Hospital	3,004	12,603	$ 1,543,398	$ 845.58	0.06	$ 7.60	9.0%
Pharmacy	20,644	53,637	$ 1,205,152	$ 22.47	0.26	$ 5.93	7.0%
Dental	28,346	127,492	$ 4,233,430	$ 33.21	0.63	$ 20.84	24.7%
Vision	9,075	20,978	$ 318,055	$ 97.50	0.10	$ 1.56	1.9%
Therapies	302	1,267	$ 32,841	$ 47.29	0.01	$ 0.16	0.2%
DME/Hearing Aids/Prosth./Orth.	400	1,102	$ 90,874	$ 222.14	0.01	$ 0.44	0.5%
Chiropracty	103	207	$ 1,467	$ 7.09	0.00	$ 0.01	0.0%
Podiatry	485	1,118	$ 37,358	$ 33.42	0.01	$ 0.18	0.2%
Home Health	217	899	$ 41,042	$ 45.65	0.00	$ 0.20	0.2%
All Other	15,966	185,238	$ 872,478	$ 4.71	0.91	$ 4.31	5.1%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 4-b
TANF/Medically Needy-Medically Indigent Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service)
Calendar Year 1997

POPULATION

Eligible Months	266,566
Average Eligibles per Month	22,214

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	129,221	748,453	$ 26,908,786	$35.95	2.81	$100.95	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	257	258	$ 6,932	$ 26.87	0.00	$ 0.03	0.0%
Other Office Visits (non-OB)	17,477	22,629	$ 498,092	$ 22.01	0.11	$ 1.87	1.9%
Prenatal Care	862	1,929	$ 104,475	$ 54.16	0.01	$ 0.39	0.4%
Emergency Room	4,047	4,428	$ 108,338	$ 24.47	0.02	$ 0.41	0.4%
All Other	9,271	64,356	$ 2,013,427	$ 26.87	0.32	$ 7.55	7.5%
Sub-Total Physicians	31,914	93,600	$ 2,731,264	$ 29.18	0.46	$ 10.25	10.2%
Clinic Services (including RHCs)	18,329	31,726	$ 4,043,042	$ 127.44	0.12	$ 15.17	15.0%
Behavioral Health							
Psychiatry	701	2,532	$ 56,199	$ 22.20	0.01	$ 0.21	0.2%
Psychology	1,100	3,856	$ 130,730	$ 33.90	0.01	$ 0.49	0.5%
Sub-Total Behavioral	1,801	6,388	$ 186,930	$ 56.10	0.02	$ 0.70	0.7%

Table 4-b

TANF/Medically Needy-Medically Indigent Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service)
Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	1,075	5,032	$ 5,682,207	$ 1,129.21	0.02	$ 21.32	21.1%
Outpatient	19,432	90,598	$ 1,766,761	$ 19.50	0.34	$ 6.63	6.6%
Sub-Total Community Hospital	20,507	95,630	$ 7,448,967	$ 77.89	0.36	$ 27.94	27.7%
County Hospital Services							
Inpatient	768	3,428	$ 2,793,552	$ 814.92	0.01	$ 10.48	10.4%
Outpatient	5,617	26,632	$ 462,667	$ 17.37	0.10	$ 1.74	1.7%
Sub-Total County Hospital	6,385	30,060	$ 3,256,220	$ 832.29	0.11	$ 12.22	12.1%
Pharmacy	28,184	70,130	$ 1,620,549	$ 23.11	0.26	$ 6.08	6.0%
Dental	36,704	168,525	$ 5,639,525	$ 33.46	0.63	$ 21.16	21.0%
Vision	13,577	31,779	$ 496,764	$ 97.60	0.12	$ 1.86	1.8%
Therapies	336	1,405	$ 36,868	$ 48.71	0.01	$ 0.14	0.1%
DME/Hearing Aids/Prosth./Orth.	594	1,550	$ 143,643	$ 256.96	0.01	$ 0.53	0.5%
Chiropracty	137	270	$ 1,903	$ 7.05	0.00	$ 0.01	0.0%
Podiatry	795	1,971	$ 64,479	$ 32.71	0.01	$ 0.24	0.2%
Home Health	385	1,411	$ 64,608	$ 45.79	0.01	$ 0.24	0.2%
All Other	20,618	222,806	$ 1,174,025	$ 5.27	0.84	$ 4.41	4.4%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 5-a
SSI-Aged Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*
Calendar Year 1997

POPULATION

Eligible Months	306,937
Average Eligibles per Month	25,578

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	227,687	$ 20,076,388	$ 140,662,243	$7.01	65.41	$458.28	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	0	0	$ -	$ -	0.00	$ -	0.0%
Other Office Visits (non-OB)	16,024	27,551	$ 622,021	$ 22.58	0.14	$ 2.03	0.4%
Prenatal Care	0	0	$ -	$ -	0.00	$ -	0.0%
Emergency Room	445	492	$ 18,937	$ 38.49	0.00	$ 0.06	0.0%
All Other	86,559	0	$ 5,968,845	$ -	0.00	$ 19.45	4.2%
Sub-Total Physicians	103,028	28,043	$ 6,609,802	$ 235.70	0.14	$ 21.54	4.7%
Clinic Services (including RHCs)	18,555	30,611	$ 2,020,491	$ 66.01	0.10	$ 6.58	1.4%
Behavioral Health							
Psychiatry	234	1,044	$ 13,214	$ 12.66	0.00	$ 0.04	0.0%
Psychology	324	975	$ 25,874	$ 26.54	0.00	$ 0.08	0.0%
Sub-Total Behavioral	558	2,019	$ 39,088	$ 39.20	0.01	$ 0.12	0.0%

Table 5-a

SSI-Aged Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	3,612	18,277	$ 7,220,563	$ 395.06	0.06	$ 23.52	5.1%
Outpatient	23,241	91,638	$ 1,973,488	$ 21.54	0.30	$ 6.43	1.4%
Sub-Total Community Hospital	26,853	109,915	$ 9,194,051	$ 83.65	0.36	$ 29.95	6.5%
County Hospital Services							
Inpatient	489	2,396	$ 1,039,547	$ 433.87	0.01	$ 3.39	0.7%
Outpatient	3,958	293,733	$ 264,148	$ 0.90	0.96	$ 0.86	0.2%
Sub-Total County Hospital	4,447	296,129	$ 1,303,695	$ 434.77	0.97	$ 4.25	0.9%
Pharmacy	154,070	1,568,370	$ 17,750,988	$ 11.32	5.11	$ 57.83	12.6%
Dental	18,813	77,124	$ 3,534,246	$ 45.83	0.25	$ 11.51	2.5%
Vision	27,794	78,763	$ 1,255,929	$ 96.01	0.26	$ 4.09	0.9%
Therapies	1,501	2,859	$ 261,362	$ 97.24	0.01	$ 0.85	0.2%
DME/Hearing Aids/Prosth./Orth.	7,625	14,632	$ 956,955	$ 298.87	0.05	$ 3.11	0.7%
Chiropracty	72	142	$ 884	$ 6.22	0.00	$ -	0.0%
Podiatry	9,012	13,617	$ 308,834	$ 22.68	0.04	$ 1.01	0.2%
Home Health	316	2,823	$ 114,157	$ 40.44	0.01	$ 0.37	0.1%
All Other	64,767	17,528,010	$ 97,311,761	$ 5.55	57.11	$ 317.07	69.2%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 5-b
SSI-Aged Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - Ex*cluding LTC*
Calendar Year 1997

POPULATION

Eligible Months	306,937
Average Eligibles per Month	25,578

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	201,898	19,352,887	$ 47,751,347	$2.47	63.05	$155.57	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	0	0	$ -	$ -	0.00	$ -	0.0%
Other Office Visits (non-OB)	16,024	27,551	$ 622,021	$ 22.58	0.14	$ 2.03	1.3%
Prenatal Care	0	0	$ -	$ -	0.00	$ -	0.0%
Emergency Room	445	492	$ 18,937	$ 38.49	0.00	$ 0.06	0.0%
All Other	86,559	0	$ 5,968,845	$ -	0.00	$ 19.45	12.5%
Sub-Total Physicians	103,028	28,043	$ 6,609,802	$ 235.70	0.14	$ 21.54	13.8%
Clinic Services (including RHCs)	18,555	30,611	$ 2,020,491	$ 66.01	0.10	$ 6.58	4.2%
Behavioral Health							
Psychiatry	234	1,044	$ 13,214	$ 12.66	0.00	$ 0.04	0.0%
Psychology	324	975	$ 25,874	$ 26.54	0.00	$ 0.08	0.1%
Sub-Total Behavioral	558	2,019	$ 39,088	$ 39.20	0.01	$ 0.12	0.1%

Table 5-b

SSI-Aged Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Excluding LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	3,612	18,277	$ 7,220,563	$ 395.06	0.06	$ 23.52	15.1%
Outpatient	23,241	91,638	$ 1,973,488	$ 21.54	0.30	$ 6.43	4.1%
Sub-Total Community Hospital	26,853	109,915	$ 9,194,051	$ 83.65	0.36	$ 29.95	19.3%
County Hospital Services							
Inpatient	489	2,396	$ 1,039,547	$ 433.87	0.01	$ 3.39	2.2%
Outpatient	3,958	293,733	$ 264,148	$ 0.90	0.96	$ 0.86	0.6%
Sub-Total County Hospital	4,447	296,129	$ 1,303,695	$ 434.77	0.97	$ 4.25	2.7%
Pharmacy	154,070	1,568,370	$ 17,750,988	$ 11.32	5.11	$ 57.83	37.2%
Dental	18,813	77,124	$ 3,534,246	$ 45.83	0.25	$ 11.51	7.4%
Vision	27,794	78,763	$ 1,255,929	$ 96.01	0.26	$ 4.09	2.6%
Therapies	1,501	2,859	$ 261,362	$ 97.24	0.01	$ 0.85	0.5%
DME/Hearing Aids/Prosth./Orth.	7,625	14,632	$ 956,955	$ 298.87	0.05	$ 3.11	2.0%
Chiropracty	72	142	$ 884	$ 6.22	0.00	$ -	0.0%
Podiatry	9,012	13,617	$ 308,834	$ 22.68	0.04	$ 1.01	0.6%
Home Health	316	2,823	$ 114,157	$ 40.44	0.01	$ 0.37	0.2%
All Other	38,978	16,804,509	$ 4,400,865	$ 0.26	54.75	$ 14.36	9.2%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 6-a
SSI-Blind Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*
Calendar Year 1997

POPULATION

Eligible Months	12,419
Average Eligibles per Month	1,035

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	9,305	1,242,446	$ 5,734,436	$4.62	100.04	$461.75	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	0	0	$ -	$ -	0.00	$ -	0.0%
Other Office Visits (non-OB)	1,203	1,905	$ 41,676	$ 21.88	0.15	$ 3.36	0.7%
Prenatal Care	1	3	$ 150	$ 50.00	0.00	$ 0.01	0.0%
Emergency Room	109	128	$ 4,233	$ 33.07	0.01	$ 0.34	0.1%
All Other	2,896	16,183	$ 325,915	$ -	1.30	$ 26.24	5.7%
Sub-Total Physicians	4,209	18,219	$ 371,974	$ 20.42	1.47	$ 29.95	6.5%
Clinic Services (including RHCs)	523	867	$ 92,801	$ 107.04	0.07	$ 7.47	1.6%
Behavioral Health							
Psychiatry	70	157	$ 5,913	$ 37.66	0.01	$ 0.48	0.1%
Psychology	43	169	$ 4,139	$ 24.49	0.01	$ 0.33	0.1%
Sub-Total Behavioral	113	326	$ 10,052	$ 62.15	0.03	$ 0.81	0.2%

Table 6-a

SSI-Blind Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	205	1,086	$ 537,068	$ 494.54	0.09	$ 43.25	9.4%
Outpatient	1,736	7,664	$ 200,556	$ 26.17	0.62	$ 16.15	3.5%
Sub-Total Community Hospital	1,941	8,750	$ 737,624	$ 84.30	0.71	$ 59.39	12.9%
County Hospital Services							
Inpatient	40	175	$ 90,661	$ 518.06	0.01	$ 7.30	1.6%
Outpatient	293	1,432	$ 20,471	$ 14.30	0.12	$ 1.65	0.4%
Sub-Total County Hospital	333	1,607	$ 111,132	$ 532.36	0.13	$ 8.95	1.9%
Pharmacy	6,596	40,963	$ 978,381	$ 23.88	3.30	$ 78.78	17.1%
Dental	812	3,259	$ 147,929	$ 45.39	0.26	$ 11.91	2.6%
Vision	825	2,336	$ 45,678	$ 103.97	0.19	$ 3.68	0.8%
Therapies	53	109	$ 6,553	$ 68.83	0.01	$ 0.53	0.1%
DME/Hearing Aids/Prosth./Orth.	371	833	$ 63,203	$ 335.80	0.07	$ 5.09	1.1%
Chiropracty	0	0	$ -	$ -	0.00	$ -	0.0%
Podiatry	375	526	$ 10,455	$ 19.88	0.04	$ 0.84	0.2%
Home Health	48	2,206	$ 51,450	$ 23.32	0.18	$ 4.14	0.9%
All Other	3,266	1,163,548	$ 3,107,205	$ 2.67	93.69	$ 250.21	54.2%

City and County of San Francisco

Historical Data -- Potential Section 1115 Waiver Eligibles

Table 6-b

SSI-Blind Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Excluding LTC*

Calendar Year 1997

POPULATION

Eligible Months	12,419
Average Eligibles per Month	1,035

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	8,423	1,222,100	$ 3,082,510	$2.52	98.41	$248.21	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	0	0	$ -	$ -	0.00	$ -	0.0%
Other Office Visits (non-OB)	1,203	1,905	$ 41,676	$ 21.88	0.15	$ 3.36	1.4%
Prenatal Care	1	3	$ 150	$ 50.00	0.00	$ 0.01	0.0%
Emergency Room	109	128	$ 4,233	$ 33.07	0.01	$ 0.34	0.1%
All Other	2,896	16,183	$ 325,915	$ -	1.30	$ 26.24	10.6%
Sub-Total Physicians	4,209	18,219	$ 371,974	$ 20.42	1.47	$ 29.95	12.1%
Clinic Services (including RHCs)	523	867	$ 92,801	$ 107.04	0.07	$ 7.47	3.0%
Behavioral Health							
Psychiatry	70	157	$ 5,913	$ 37.66	0.01	$ 0.48	0.2%
Psychology	43	169	$ 4,139	$ 24.49	0.01	$ 0.33	0.1%
Sub-Total Behavioral	113	326	$ 10,052	$ 62.15	0.03	$ 0.81	0.3%

Table 6-b

SSI-Blind Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Excluding LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Pct of Total
Community Hospital Services							
Inpatient	205	1,086	$ 537,068	$ 494.54	0.09	$ 43.25	17.4%
Outpatient	1,736	7,664	$ 200,556	$ 26.17	0.62	$ 16.15	6.5%
Sub-Total Community Hospital	1,941	8,750	$ 737,624	$ 84.30	0.71	$ 59.39	23.9%
County Hospital Services							
Inpatient	40	175	$ 90,661	$ 518.06	0.01	$ 7.30	2.9%
Outpatient	293	1,432	$ 20,471	$ 14.30	0.12	$ 1.65	0.7%
Sub-Total County Hospital	333	1,607	$ 111,132	$ 532.36	0.13	$ 8.95	3.6%
Pharmacy	6,596	40,963	$ 978,381	$ 23.88	3.30	$ 78.78	31.7%
Dental	812	3,259	$ 147,929	$ 45.39	0.26	$ 11.91	4.8%
Vision	825	2,336	$ 45,678	$ 103.97	0.19	$ 3.68	1.5%
Therapies	53	109	$ 6,553	$ 68.83	0.01	$ 0.53	0.2%
DME/Hearing Aids/Prosth./Orth.	371	833	$ 63,203	$ 335.80	0.07	$ 5.09	2.1%
Chiropracty	0	0	$ -	$ -	0.00	$ -	0.0%
Podiatry	375	526	$ 10,455	$ 19.88	0.04	$ 0.84	0.3%
Home Health	48	2,206	$ 51,450	$ 23.32	0.18	$ 4.14	1.7%
All Other	2,384	1,143,202	$ 455,279	$ 0.40	92.05	$ 36.67	14.8%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 7-a
SSI-Disabled Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*
Calendar Year 1997

POPULATION

Eligible Months	340,785
Average Eligibles per Month	28,399

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
TOTAL - ALL CATEGORIES	247,750	11,452,769	$ 159,148,343	$13.90	33.61	$467.01	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	10	10	$ 356	$ 35.55	0.00	$ -	0.0%
Other Office Visits (non-OB)	26,573	41,018	$ 911,473	$ 22.22	0.20	$ 2.67	0.6%
Prenatal Care	50	126	$ 5,762	$ 45.73	0.00	$ 0.02	0.0%
Emergency Room	9,180	11,989	$ 370,427	$ 30.90	0.06	$ 1.09	0.2%
All Other	55,878	351,880	$ 8,470,079	$ 35.55	1.73	$ 24.85	5.3%
Sub-Total Physicians	91,691	405,023	$ 9,758,097	$ 24.09	1.99	$ 28.63	6.1%
Clinic Services (including RHCs)	32,250	64,791	$ 8,078,352	$ 124.68	0.19	$ 23.71	5.1%
Behavioral Health							
Psychiatry	7,785	29,102	$ 721,290	$ 24.78	0.09	$ 2.12	0.5%
Psychology	1,669	6,242	$ 173,687	$ 27.83	0.02	$ 0.51	0.1%
Sub-Total Behavioral	9,454	35,344	$ 894,977	$ 52.61	0.10	$ 2.63	0.6%

Table 7-a

SSI-Disabled Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Including LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	4,528	26,578	$ 15,833,720	$ 595.75	0.08	$ 46.46	9.9%
Outpatient	43,989	252,265	$ 5,352,278	$ 21.22	0.74	$ 15.71	3.4%
Sub-Total Community Hospital	48,517	278,843	$ 21,185,998	$ 75.98	0.82	$ 62.17	13.3%
County Hospital Services							
Inpatient	3,211	20,840	$ 14,907,653	$ 715.34	0.06	$ 43.75	9.4%
Outpatient	22,285	232,319	$ 2,093,949	$ 9.01	0.68	$ 6.14	1.3%
Sub-Total County Hospital	25,496	253,159	$ 17,001,603	$ 724.35	0.74	$ 49.89	10.7%
Pharmacy	169,812	1,143,091	$ 41,721,937	$ 36.50	3.35	$ 122.43	26.2%
Dental	24,356	98,120	$ 4,071,296	$ 41.49	0.29	$ 11.95	2.6%
Vision	25,091	65,679	$ 1,101,531	$ 97.62	0.19	$ 3.23	0.7%
Therapies	1,045	6,099	$ 115,334	$ 59.15	0.02	$ 0.33	0.1%
DME/Hearing Aids/Prosth./Orth.	6,541	20,092	$ 1,736,702	$ 320.76	0.06	$ 5.09	1.1%
Chiropracty	438	917	$ 6,290	$ 6.86	0.00	$ 0.02	0.0%
Podiatry	6,683	11,090	$ 244,723	$ 22.07	0.03	$ 0.72	0.2%
Home Health	1,502	31,015	$ 1,153,675	$ 37.20	0.09	$ 3.39	0.7%
All Other	54,941	9,076,334	$ 52,077,829	$ 5.74	26.63	$ 152.82	32.7%

City and County of San Francisco

Historical Data -- Potential Section 1115 Waiver Eligibles

Table 7-b

SSI-Disabled Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Excluding LTC*

Calendar Year 1997

POPULATION

Eligible Months	340,785
Average Eligibles per Month	28,399

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Pct of Total
TOTAL - ALL CATEGORIES	238,088	11,203,743	$ 115,376,606	$10.30	32.88	$338.56	100.0%
Physician Services (Non-Psychiatric)							
Preventive Care	10	10	$ 356	$ 35.55	0.00	$ -	0.0%
Other Office Visits (non-OB)	26,573	41,018	$ 911,473	$ 22.22	0.20	$ 2.67	0.8%
Prenatal Care	50	126	$ 5,762	$ 45.73	0.00	$ 0.02	0.0%
Emergency Room	9,180	11,989	$ 370,427	$ 30.90	0.06	$ 1.09	0.3%
All Other	55,878	351,880	$ 8,470,079	$ 35.55	1.73	$ 24.85	7.3%
Sub-Total Physicians	91,691	405,023	$ 9,758,097	$ 24.09	1.99	$ 28.63	8.5%
Clinic Services (including RHCs)	32,250	64,791	$ 8,078,352	$ 124.68	0.19	$ 23.71	7.0%
Behavioral Health							
Psychiatry	7,785	29,102	$ 721,290	$ 24.78	0.09	$ 2.12	0.6%
Psychology	1,669	6,242	$ 173,687	$ 27.83	0.02	$ 0.51	0.2%
Sub-Total Behavioral	9,454	35,344	$ 894,977	$ 52.61	0.10	$ 2.63	0.8%

Table 7-b

SSI-Disabled Eligibles - Service Usage and Per Member Per Month Costs (Fee-for-Service) - *Excluding LTC*

Calendar Year 1997

Category of Service	# of Users	Units of Service or Days of Care	Expenditures	Avg. Cost Per Unit/Day	Units/Days Per Eligible Mo.	Per Member Per Month Avg. Cost	Per Member Per Month Pct of Total
Community Hospital Services							
Inpatient	4,528	26,578	$ 15,833,720	$ 595.75	0.08	$ 46.46	13.7%
Outpatient	43,989	252,265	$ 5,352,278	$ 21.22	0.74	$ 15.71	4.6%
Sub-Total Community Hospital	48,517	278,843	$ 21,185,998	$ 75.98	0.82	$ 62.17	18.4%
County Hospital Services							
Inpatient	3,211	20,840	$ 14,907,653	$ 715.34	0.06	$ 43.75	12.9%
Outpatient	22,285	232,319	$ 2,093,949	$ 9.01	0.68	$ 6.14	1.8%
Sub-Total County Hospital	25,496	253,159	$ 17,001,603	$ 724.35	0.74	$ 49.89	14.7%
Pharmacy	169,812	1,143,091	$ 41,721,937	$ 36.50	3.35	$ 122.43	36.2%
Dental	24,356	98,120	$ 4,071,296	$ 41.49	0.29	$ 11.95	3.5%
Vision	25,091	65,679	$ 1,101,531	$ 97.62	0.19	$ 3.23	1.0%
Therapies	1,045	6,099	$ 115,334	$ 59.15	0.02	$ 0.33	0.1%
DME/Hearing Aids/Prosth./Orth.	6,541	20,092	$ 1,736,702	$ 320.76	0.06	$ 5.09	1.5%
Chiropracty	438	917	$ 6,290	$ 6.86	0.00	$ 0.02	0.0%
Podiatry	6,683	11,090	$ 244,723	$ 22.07	0.03	$ 0.72	0.2%
Home Health	1,502	31,015	$ 1,153,675	$ 37.20	0.09	$ 3.39	1.0%
All Other	45,279	8,827,308	$ 8,306,091	$ 0.94	25.90	$ 24.37	7.2%

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 8
Summary of Costs by Aid Category
Calendar Year 1997

Service Type	TANF Only	TANF/MN-MI	Aged	Blind	Disabled
Physician Services	$ 7.38	$ 10.25	$ 21.54	$ 29.95	$ 28.63
Clinic Services	11.45	15.17	6.58	7.47	23.71
Behavioral Health	0.85	0.70	0.12	0.81	2.63
Community Hospital	23.41	27.94	29.95	59.39	62.17
County Hospital	7.60	12.22	4.25	8.95	49.89
Pharmacy	5.93	6.08	57.83	78.78	122.43
Dental	20.84	21.16	11.51	11.91	11.95
Vision	1.56	1.86	4.09	3.68	3.23
Therapies	0.16	0.14	0.85	0.53	0.33
DME/Aids/Prosth./Orth.	0.44	0.53	3.11	5.09	5.09
Chiropracty	0.01	0.01	-	-	0.02
Podiatry	0.18	0.24	1.01	0.84	0.72
Home Health	0.20	0.24	0.37	4.14	3.39
All Other	4.00	3.75	14.37	36.68	24.37
Day, Intermed & L-T Care	0.31	0.66	302.70	213.53	128.45
Total	**$ 84.32**	**$ 100.95**	**$ 458.28**	**$ 461.75**	**$ 467.01**

Source: Medi-Cal Services and Expenditures Month-of-Payment Report from January to December, 1997

Table 9
TANF/SSI Costs
Comparison to Other Programs

State or County	Year Starting:	TANF	Blind/Disabled	Ratio: BD-to-TANF	As Pct. of SF	
					TANF	Blind/Disabled
San Francisco	Jan-97	$100.95	$ 335.38	3.3	100%	100%
Los Angeles	Oct-96	$ 68.91	$ 196.74	2.9	68%	59%
Alabama (Mobile Co.)	Apr-97	$ 165.88	$ 265.50	1.6	164%	79%
Arizona (Maricopa Co.)	Oct-96	$ 121.08	$ 331.61	2.7	120%	99%
New York (Westch. Co.)	Jan-98	$ 137.82	$ 500.10	3.6	137%	149%
Vermont	Jan-98	$ 73.71	$ 292.99	4.0	73%	87%

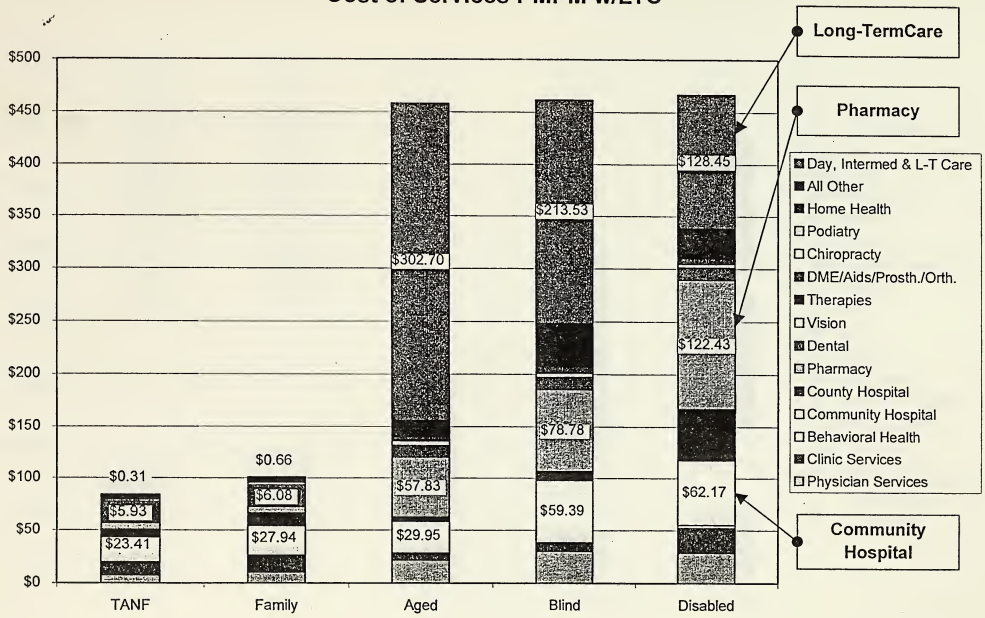
Notes:

1 LA TANF values are capitation rates within two-plan program and exclude MN/MI

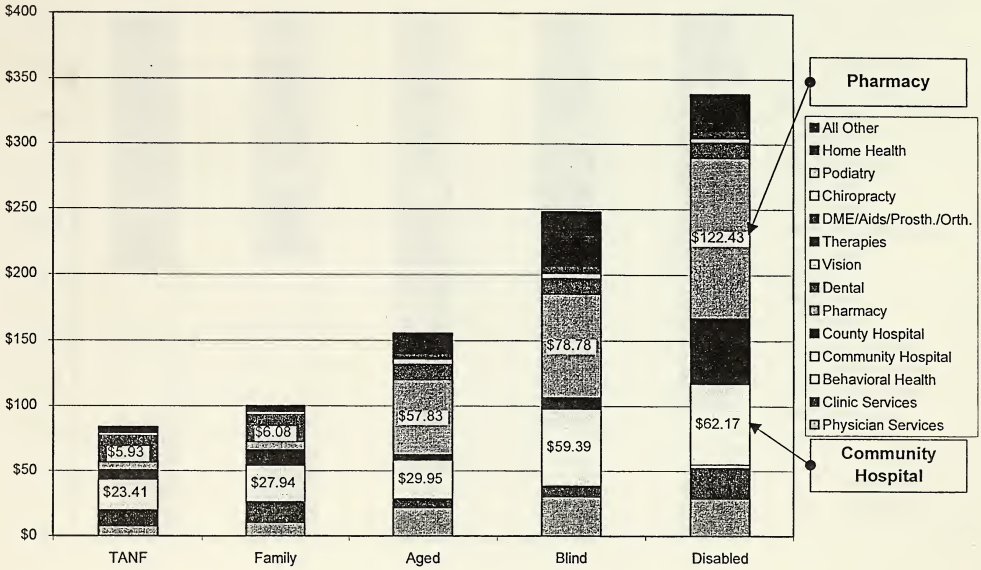
2 Alabama TANF comprised primarily of children under age six and pregnant women (resulting in higher than average costs)

3 Arizona data is capitation rate for largest health plan in Phoenix; does not include maternity costs

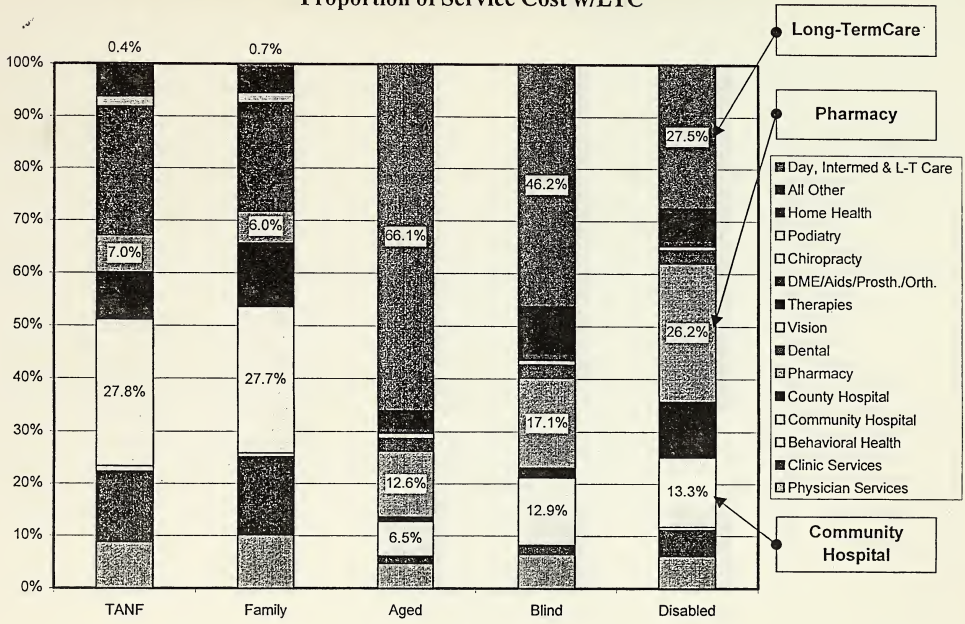
4 Alabama TANF comprised primarily of children under age six and pregnant women (resulting in higher than average costs)


Cost of Services PMPM w/LTC
Long-TermCare
Pharmacy
Community Hospital
$500
$450
$400
$350
$300
$250
$200
$150
$100
$50
$0
$0.31
$5.93
$23.41
$0.66
$6.08
$27.94
$302.70
$57.83
$29.95
$213.53
$78.78
$59.39
$128.45
$122.43
$62.17
TANF
Family
Aged
Blind
Disabled
Day, Intermed & L-T Care
All Other
Home Health
Podiatry
Chiropracty
DME/Aids/Prosth./Orth.
Therapies
Vision
Dental
Pharmacy
County Hospital
Community Hospital
Behavioral Health
Clinic Services
Physician Services

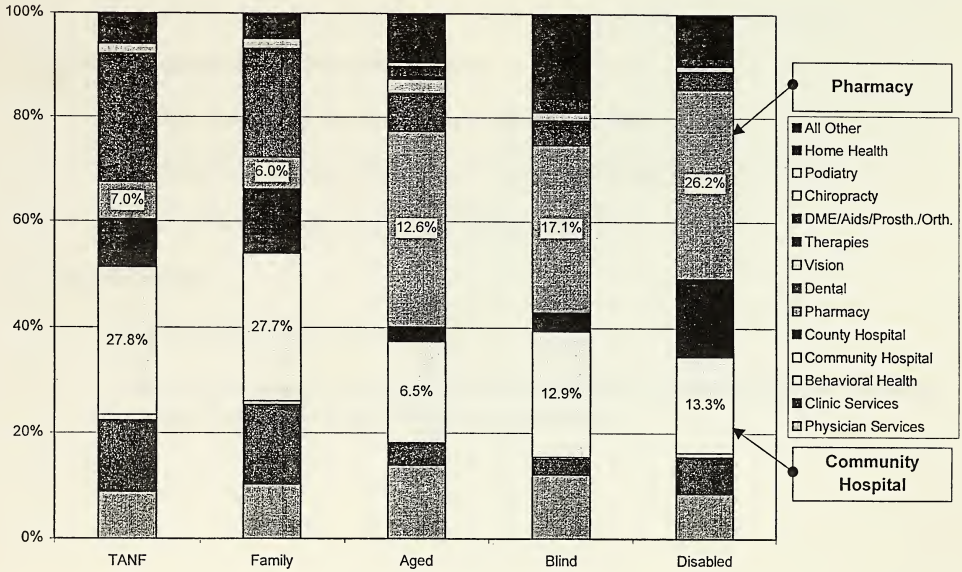
Cost of Services PMPM w/o LTC



Proportion of Service Cost w/LTC



Proportion of Service Cost w/o LTC



PROFILE OF WAIVER-ELIGIBLE POPULATIONS

Historical Costs - Comments

- TANF/Medically Needy-Medically Indigent

  Relatively low PMPM costs in fee-for-service program

  Unusually high dental expenditures -- restorative dental

  Low capitation rates; no room for further reductions

- Blind/Disabled

  Very high pharmacy costs

  Low to low-average costs in fee-for-service program, excluding pharmacy (assuming average behavioral health dollars not shown here)

City and County of San Francisco
Historical Data -- Potential Section 1115 Waiver Eligibles

Table 10
SSI Dollars for Coverage Expansion - "Order of Magnitude" Estimate

Pct. of FFS	Eligible Months	FFS	MC	Total Dollars	Expansion	
					Capitation	Population
100%	353,204	$ 335.38	$ 335.38	$ -	$84.32	0
99%	353,204	$ 335.38	$ 332.03	$ 1,184,591	$84.32	1,171
95%	353,204	$ 335.38	$ 318.62	$ 5,922,956	$84.32	5,854
90%	353,204	$ 335.38	$ 301.85	$ 11,845,912	$84.32	11,707
85%	353,204	$ 335.38	$ 285.08	$ 17,768,867	$84.32	17,561
80%	353,204	$ 335.38	$ 268.31	$ 23,691,823	$84.32	23,415

Note: "Capitation" set equal to TANF PMPM cost

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Health Commission

Revised: December 1, 1998

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

October 28, 1998
2:00 - 5:00pm
25 Van Ness, Room 330

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MINUTES

Present: George Babcock (for Janet Olsen-Coyle); Richard Gibbs, M.D.; John Gressman; Carolayn Hughes; Bruce Livingston; Nathan Nayman; Shahnaz Nikpay; Nancy Presson; Nancy Snow (for James Hickman); Robin Strimling; Tony Wagner; Mary Wong

Guests: Mary Bading (consultant); Merrill Buice; Jack Fries; David Ishida; Cyndy Johnson (consultant);

Staff: Tangerine Brigham; Richard Hodgson

1. Introduction/ Approval of Minutes of September 23, 1998

Item 18) page 2 - The consultant requested that the phrase "preliminary conclusion" be revised to "preliminary finding." The Committee approved the minutes with that correction.

2. Subcommittee Reports

Staff distributed a summary of the issues considered, deliberations and preliminary recommendations of the three Subcommittees. Mr. Hodgson noted that the recommendations were more preliminary findings than formal recommendations and were intended to assist the consultants in proceeding with the feasibility analysis regarding whether and/ or how to proceed with the waiver proposal development. Ms. Brigham noted that the waiver planning was at a critical juncture at which the feasibility and desirability of going forward with a waiver needs to be assessed based on some reasonably good numbers on utilization, costs and system impacts. She noted that the feasibility of proceeding with the waiver planning needs to be placed into the context of other planning processes (e.g., Long Term Care Integration Pilot Project, County Organized Health System - COHS) that continue to move along parallel tracks.

Ms. Brigham noted that the COHS legislation did not go forward in Congress and is now dead. A COHS-like plan could still be developed under a 1115 waiver as an alternative to the two plan model. Also, COHS legislation could be resurrected as part of the budget reconciliation bill next year. The negative External Quality Review Organization (EQRO) report on Medi-Cal managed care prepared under State auspices and subsequent lobbying by the Western Law and Poverty Center may have impacted the legislation. The EQRO report, however, criticizes Medi-Cal managed care in general, not just the COHSs; criticism is primarily on medical recordkeeping and not quality of care. Under

legislation approved last session, COHSs can now link to other counties; total Statewide COHS enrollment still has to be under the 10% cap (i.e., 10% of total Statewide Medi-Cal eligibles).

Each Subcommittee chair reported on the deliberations and preliminary findings of his/ her Subcommittee. (As Amy Lee was unable to attend this meeting, David Ishida reported on Financing and Data.) This Committee offered the following comments/ questions regarding the Subcommittee reports. Reponses by the consultants and staff are noted:

1) How many Healthy Families applicants have turned out to be Medi-Cal eligible? Statewide, it is 50% total. Some people just do not want to participate in Medi-Cal and see Healthy Families as a desirable alternative. The Healthy Families application process and program is being revamped to increase enrollments.
2) The State is pursuing a waiver for Institutes for Mental Diseases (IMD) matching funding - staff will get information from Janet Olsen-Coyle/ George Babcock on this matter.
3) Will the waiver focus on social services also or medical care only? Answer: Capitation payments to a waiver plan can be used at that plan's discretion to provide services deemed necessary to maintain clients' health; these services can include social services. Program funding, however, must first cover the basic health benefits package for all enrollees.
4) There should be one system proposed - coordinated and comprehensive and including all services.
5) The feasibility study should describe the type of managed care model proposed for the waiver program. Options include:
   a) Primary Care Case Management (PCCM) - more limited risk; covers ambulatory care only under managed care; inpatient is paid fee-for-service
   b) Health Maintenance Organization (HMO) - fully-capitated for inpatient and outpatient services
   c) Mixed (CalOptima model) - some categories of high care needs clients under direct fee-for-service; some partially capitated; some fully capitated
6) Does SF have the potential Medi-Cal enrollments for two plans plus a fee-for-service direct program? Answer: no.
7) CalOptima (Orange County) is a COHS single-plan model but with many network plans under its umbrella. Plan choice is maintained under a single-plan framework.
8) For the seriously mentally ill, Medicaid is their health insurance nationally.
9) New York has received HCFA approval for two Special Needs Plans (i.e., carve-outs from the basic 1115 waiver plan) - 1) HIV/ AIDS and 2) Seriously Mentally Ill (SMI). Neither, however, is fully operational to date.
10) A managed care plan can use target budgets to control the costs of special needs plans and fee-for-service direct components (essentially a variation of fee-for-service managed care).
11) SF spends millions on health services for the uninsured.
    a) Can those funds be used more efficiently?

b) Would they go with the uninsured into a waiver program to leverage Medi-Cal dollars saved or added through increased matching funds?

Answer: A principal purpose of the waiver is to focus on the federal dollars and to gain local control of them for more flexible use. The priority for spending local dollars is a policy decision to be addressed further down the line.

3. Actions Required to Complete the 1115 Waiver Feasibility Analysis

Based on the input from the Subcommittees and this meeting, the Committee endorsed having the consultants proceed to generate a report on the feasibility and desirability of San Francisco moving forward with the development of a waiver proposal. The study will evaluate the pros and cons of a waiver for San Francisco and focus on how various issues identified during this planning process could be addressed. The feasibility analysis will be detailed regarding the costs of various strategic options and the benefits to be derived from alternative approaches.

In order to have the time to complete this feasibility analysis and mail it to the Committee in advance for review, **the scheduled November 18, 1998 meeting of this Committee is cancelled. The Committee will next meet:**

December, 9 1998
Noon-4:30pm*
(Lunch will be provided)
25 Van Ness, Room 330

Please call Richard Hodgson at 5542627 if you will be unable to make the meeting or have questions at this time.

***PLEASE NOTE THE CHANGED START TIME.** To have sufficient time to review the feasibility analysis in detail, the meeting will start at noon and end no later than 4:30pm.

Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, December 9, 1998
Noon – 4:30pm
25 Van Ness, Room 330

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(Lunch will be provided for Committee and Subcommittee members)

AGENDA

	Item	Process	Time
I.	**Introduction/ Approval of Minutes of October 28, 1998**	Action	12:00-12:15pm
II.	**Waiver Feasibility Study**	Information/ Discussion	12:15-4:00pm
III.	**Next Steps**	Discussion	4:00-4:30pm
IV.	**New Business**		

Background Materials (attached):

- Minutes of October 28, 1998 (Filed under Minutes)
- Waiver Feasibility Study (12/9/98 Sent to be cataloged)

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Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, December 9, 1998
Noon – 4:30pm
25 Van Ness, Room 330

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MINUTES

PRESENT:
George Babcock (for Janet Olsen-Coyle); John Borsos; Richard Gibbs, M.D.; James Hickman; Irwin Hoff; Mitch Katz, M.D. (Chair); Bruce Livingston; Amy Lee; Nathan Nayman; Shahnaz Nikpay; Manuel Rubio (for Guillermo Rodriguez); Robin Strimling; Tony Wagner; Mary Wong

GUESTS:
Merrill Buice; John D. R. Clark; Carol Freels; Jack Fries; Bill Haskell; Kathleen Haviland; David Ishida; Ann Iverson; Marie Jobling; Michael Keys; Diane Miller; Brett Nair; Anthony Nicco; Gene O'Connell; Jana Overbo; Bob Prentice; Liz Strand; Melissa Welch, M.D.; Monique Zmuda

STAFF:
Tangerine Brigham; Richard Hodgson

CONSULTANTS:
Mary Bading; Andy Cohen; Cyndy Johnson

I. Introduction/ Approval of the Minutes of October 28, 1998

Dr. Katz called the meeting to order and reviewed the goals of this meeting:

a. Review the Medicaid 1115 waiver feasibility study prepared by the consultants to present scenarios and options under which it might be feasible for San Francisco to submit a waiver application to the State and HCFA.
b. Recommend to the Health Commission if and under what conditions San Francisco should pursue a waiver and which of the scenarios considered seems to be the most viable and beneficial to San Francisco.

II. Waiver Feasibility Study

Cyndy Johnson, Mary Bading and Andy Cohen, consultants - Pacific Health Policy Group - presented the highlights of the feasibility study. This study examines the feasibility of San Francisco pursuing a Medicaid 1115 waiver and presents options for identifying Medicaid savings and expanding coverage to the uninsured. The Committee raised the following questions and issues regarding the study:

A. Extending Health Care Coverage to New Populations

- If ADAP covers protease inhibitors for HIV+ patients from "Day One", why is the "Day One" HIV+ option included in the four scenarios to extend coverage? Response: ADAP does not cover all necessary prescription drugs and estimates are that there still are a significant number of HIV+ patients who are low income uninsured. Further research will be conducted on what ADAP does and does not pay for.
- The uninsured population will grow as TANF eligibility and transitional Medi-Cal expire for individuals. Does this analysis take this into account? Response: No adjustment was made to recognize a potential increase in the number of uninsured. The waiver financial model proposed would only cover a portion of the **current** uninsured in and of itself. A 1115 waiver is only a partial solution to covering SF's uninsured.
- Can we achieve a higher match rate for CHIP (e.g., California's Healthy Families program) under a waiver? State legislation has been introduced to increase the income level for Healthy Families to 250% of the Federal Poverty Level (FPL). Response: It is not likely at this time; Vermont could not get the CHIP match rate increased for the underinsured.

B. Enrolling New Medi-Cal Eligibiles

- The assumption that 80% of the hypotheticals (1902r children and 1931b adults) would enroll under the waiver seems high; they have not enrolled before when opportunities were available. Also, if you target 80% for enrollment, you have to enroll 80% as a base for your managed care financial projections to work.
- Can new dollars for the "hypotheticals" be achieved on a sub-state basis? HCFA may not approve this because they have disapproved similar proposals in the past. The financial analysis shows that the State will not fund the local match for "hypotheticals"; this would be SF's (i.e., County-specific) responsibility.

C. Addressing Behavioral Health in the Waiver Planning

- Why is behavioral health (mental health and substance abuse services) not included in the proposal and financial analysis?

  Responses:
  a. Behavioral health could still be included in a 1115 waiver program without being in the basic physical health plan administratively.
  b. If behavioral health dollars were earmarked for behavioral health, no savings could accrue to the physical health plan by including them; therefore, they would be a wash as far as this analysis is concerned.
  c. Behavioral health providers are concerned that a blending of behavioral and physical health funding will result in a decrease in funding for behavioral health services.
  d. Mental health managed care just started in SF and it needs a chance to succeed and be evaluated before changes are proposed.
  e. The database used for the feasibility analysis did not include a way of identifying behavioral health clients and their utilization.

D. Waiver Managed Care Models - Primary Care Case Management, Care Coordination, Health Maintenance Organization

- The definition of Primary Care Case Management being used in this analysis should be clarified. Is it the State's definition in which the State retains responsibility for the non-gatekeeper component of the health care plan or is it the definition that includes all components but with the gatekeeper component only being capitated/ at risk? Response: The model has not been developed to that level of detail yet. However, a comprehensive waiver plan would include all components but perhaps put only the gatekeeper component in capitation/ at risk. This model is perhaps more palatable initially for SSI providers than complete HMO-style capitation and could be a transitional phase to complete capitation in a later stage. With relation to high-risk populations, nationally the top 3 SSI high needs/ high utilization conditions are: heart disease, diabetes and mental illness.
- Patients with high care needs require more physician time as well as intensified services. Accordingly, a PCCM or partially-capitated model potentially offers more flexibility than an HMO model for providing these higher levels of service.
- Care coordination through a PCCM model may not be the panacea it appears to be. Coordinating care from disparate providers may take more time and money and be less efficient than putting everything under the unified control of a single HMO system.
- Does the HIPC preferred capitation rate recognize that the low-income uninsured have higher medical needs than uninsured with higher incomes? Response: The HIPC population generally has a lower level of medical needs than the indigent uninsured.
- Can we add co-payments/ premiums/ employer contributions for expansion groups later? Response: Yes.

E. Achieving Medi-Cal Cost Savings

- Are the savings at start up reasonable targets? Response: They are based on 95% of FFS and are very modest savings targets; a well-managed care coordination system should be able to achiever greater savings.
- It must be reiterated that Medi-Cal reimbursement does not fully cover costs. Accordingly, the figures identified as "costs" in this analysis should more appropriately be labeled "Medi-Cal premium payments". Thus, savings are being sought to reduce Medi-Cal premium payments that are already below actual costs. This is may be impractical for SF's already hard-pressed safety net providers.
- Projected savings can be divided into two categories:
    a. providing services at levels more appropriate to the patients' needs (good savings); and
    b. paying providers less (bad savings - merely takes needed resources away from the safety net).

F. Waiver Financing Options

- If DSH and SB 1255 funds are being included in the waiver, why aren't State realignment and tobacco tax funds? Response: Realignment and tobacco tax funds

do not require a 1115 waiver to be used in different ways since they are not Medicaid funds.

- SF should approach the issue of financing care for the uninsured in a comprehensive manner. Components of the problem - such as the sub-set of the uninsured whose care could financed through a 1115 waiver - can not be looked at in isolation. There is overlap in various planning efforts (waiver, LTCIPP, Blue Ribbon UHC plan) and the policy decisions required can only be made by looking at the entire system at once.
- If SF does proceed with a waiver, then we should also look at Medicare DSH.
- By including SB1255 funds under the waiver, we could reduce the total amount SF could receive, because once in the budget neutrality equation, the funds could be capped. Do we really need a 1115 waiver program to tell us how to spend our DSH and SB 1255 dollars?

Cyndy Johnson noted in conclusion that a 1115 waiver is not a panacea for solving the problem of financing health coverage for all of SF's uninsured. Large amounts of new unrestricted federal dollars are not going to come through a waiver. In addition, significant work is still necessary to develop a concept paper and ultimately an application for the State and HCFA to consider. SF needs to decide if the potential benefit - getting local control of Medi-Cal dollars and covering some of the uninsured - is worth the cost - the work necessary to get an application approved and the more substantial work of changing the way health services are delivered to the SSI population.

Dr. Katz thanked the consultants for their excellent work and noted that the rest of the meeting would be devoted to feedback from the Committee particularly on the key policy issues now on the table. He further stated that he does not want to go to the Health Commission with recommendations until this Committee is comfortable with them.

The Committee offered the following comments and questions:

A. Waiver Financial Model - DSH, SB 1255, Savings

There was extensive discussion of the waiver financial model which proposes including one half of all net Disproportionate Share (DSH) revenues received in San Francisco and one half of the Department of Public Health's SB 1255 funds. In addition, the model proposes savings from converting SSI fee-for-service to managed care. The DSH and SB 1255 funds plus the savings would be used to extend health coverage to the uninsured and other vulnerable populations per the four scenarios described in the feasibility study.

Several members of the Committee expressed significant concern about including DSH and SB 1255 funds in the waiver with particular emphasis on how the proposal would enable San Francisco to meet one of its waiver guiding principles which is to "ensure that any system changes maintain a viable safety net." SF could use DSH more flexibly for outpatient services through a waiver if we obtained approval, but the revenues diverted from funding inpatient care would have to be replaced. After a waiver is in place it is unlikely that there would be a significant decrease in inpatient

expenditures, at least in the short run. With DSH diverted, DSH providers would still have to care for sicker people with fewer dollars.

An alternative would be to leave DSH and SB 1255 as is and use General Fund and State Realignment money for outpatient care. This approach would not require a waiver as these funds are under local control already.

Some members of the Committee emphasized that the $76 million dollars in potential savings identified in the study should be the focus of this discussion - not the DSH and SB 1255 dollars. The $76 million is potentially "new money" for the uninsured. The DSH is already going for care for the uninsured. Other members of the Committee felt, however, that DSH and SB 1255 funds should continue to be included in the financial analysis.

B. Comprehensive Planning for Medi-Cal and the Uninsured

The Committee expressed the need for a City-wide system of care for the uninsured and a process that ties all current planning initiatives together to achieve that system. The waiver is just one piece of the puzzle. We need to discuss all funding sources together and have a planning committee that looks at all the pieces. We also need to trend what we think will happen in the future and address those trends comprehensively using all available resources.

The Committee discussed the coordination of the 1115 waiver planning with the Long Term Care Integration Pilot Project's plan to submit its own waiver within the next three years. Submitting two waivers may not be practical for San Francisco - the SSI population is too large a component of both populations.

The Committee also discussed the projected $76 million savings which could be accrued by converting Medi-Cal fee-for-service to managed care. Some members felt that the number of uninsured who could be covered with the savings was not large enough to justify the major restructuring of services to the SSI population that would be required. Others felt that the savings represented a substantial amount of money that could be available to help finance coverage for vulnerable populations. The Committee felt that there should be further discussion of the potential savings and how they might best be used as part of the decision process regarding whether or not to proceed with the waiver planning.

C. Enrolling the SSI Population in Managed Care

- Does this Committee support moving the SSI population into a form of mandatory managed care? Would the SSI beneficiaries be served by such a change? Response: The SSI community needs to be consulted on the desirability of making this move and whether there are deficiencies in current SSI services that would be addressed by greater care coordination through a PCCM or HMO style model. The number of uninsured that could be covered by the proposed SSI savings (approximately 3,100 uninsured in 2000) is relatively small with relation to both the complex application process and the significant health care delivery system changes that would have to be

put in place to achieve the savings. There is currently consensus that the benefit is worth the investment required.

- SF should do a case study to look at the voluntary SSI enrollments into the current two-plan model to see why they chose to enroll, how they are receiving specialized services and if they are satisfied with managed care.
- We must improve quality, accessibility and/ or continuity of care for the SSI population under a waiver; don't just take the savings form reducing expenditures and use them elsewhere (e.g., to cover the uninsured). We shouldn't just squeeze provider reimbursement to achieve the savings. Do we have the provider networks in place for managed care for these specialized populations? Response: We do not know at this time whether integrated provider networks are in place to provide the full range of services.

D. Extending Medi-Cal to the Hypotheticals and Coverage to the Uninsured

- The $76 million projected savings is not a hard number - actual savings could be less but they could also be more. Identifying the savings and targeting them for coverage for the uninsured, however, increases the chances of getting federal approval for matching funds for the hypotheticals.
- Has this study factored out the undocumented in the expansion populations? They can not be included in a waiver for Medicaid funds. Response: Yes, the expansion population that could be covered under a 1115 waiver is significantly less than the total uninsured of SF.
- HCFA should be approached on the issue of approving the hypotheticals on a county-specific basis. The agency has disapproved this in the past and may be particularly concerned about a sub-state approval.

E. Feasibility and Desirability of Pursuing a Waiver

- Does this Committee wish to pursue a 1115 waiver application if the SSI community is in favor and appropriate coordination with the LTCIPP (e.g., no double-counting of populations) and the Blue Ribbon Committee planning can be achieved? Response: We need to develop a more comprehensive approach that looks in depth at these linkages and also reconsiders the "carve-outs". The parallel planning processes and the beneficiary groups and funding steams with which they deal have overlaps. Planning for one piece of the larger puzzle can not be effective because every potential policy decision effects one or more of the other pieces.
- We should continue planning for a waiver if three conditions can be met:
    - the SSI population is in favor of a managed care approach that can improve their services;
    - the waiver can fit into a more comprehensive approach to improving Medi-Cal and indigent health care services in SF; and
    - the planning continues to be consistent with the guiding principles approved earlier in the waiver planning process.
- The discussion of improving services for the disenfranchised is a good thing even if the savings identified in this study appear small. This process plants a seed. We need to get going with a program and the pieces will fall into place as we proceed. SF

could set an example for the State and nation on how to address the problem of providing health care coverage to growing numbers of the uninsured.

- The combination of bringing the hypotheticals into the system and extending coverage with the SSI savings adds enough beneficiaries (approximately 15,400 in 2000) to represent a significant step forward in extending services to SF's vulnerable populations.

III. Next Steps

The Committee recommended the following with respect to the presentation of the study to the Health Commission:

- SF should determine how various planning processes (i.e., 1115 waiver, LTCIPP, Blue Ribbon Committee implementation, County Organized Health System, behavioral health) converge into a single, comprehensive process that addresses the needs of all Medi-Cal and indigent uninsured clients.
- The entire feasibility study should be presented to the Health Commission but the emphasis should be on the $76 million in potential savings on SSI services. The presentations should note that the SSI population's needs must be studied before proceeding to make sure that proposed reforms improve services to the SSI beneficiaries - and don't merely reduce available dollars to achieve savings.
- There is no Committee consensus on retaining DSH or SB 1255 funds as part of the proposed waiver.

The report to the Health Commission (tentatively scheduled for January 5, 1999) will not seek a go/ no go decision on proceeding to develop a waiver application. Committee members, Subcommittee members and interested parties will receive copies of the report prior to the meeting. As noted above, more study is needed on the issue of whether a managed care approach could improve services to the SSI population.

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TO: Medicaid 1115 Waiver Planning Committee - Members, Subcommittee Members, Interested Parties

FROM: Tangerine Brigham RBH for

RE: **Health Commission Feedback Regarding the Medicaid 1115 Waiver Planning Process and Feasibility Analysis**

DATE: January 19, 1999

As you know, at its January 5, 1999 meeting the Health Commission reviewed the Medicaid 1115 waiver feasibility analysis.

The Commission expressed appreciation for the work of the Waiver Planning Committee, Sub-committees, consultants and staff. At the conclusion of the discussion, the Health Commission made recommendations on the next steps in this planning process. I would like to share with you the Comission's recommended actions at a special meeting noted below:

Medicaid 1115 Waiver Planning Committee Meeting
January 27, 1999
3:00 - 5:00pm
25 Van Ness, Room 330B

Attached please find the agenda for this meeting in addition to the minutes of the December 9, 1998 Waiver Planning Committee meeting. If you did not receive a copy of the January 5, 1999 Health Commission report, please call Richard Hodgson at 554-2627.

Attachments

hcfeedbmem

Health Commission

MEDICAID 1115 WAIVER PLANNING COMMITTEE MEETING

Wednesday, January 27, 1999
3:00 – 5:00pm
25 Van Ness, Room 330B

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AGENDA

	Item	Process	Time
I.	**Introduction/ Approval of Minutes of December 9, 1998**	Action	3:00-3:10pm
II.	**Update to the Health Commission/ Commission Feedback**	Information/ Discussion	3:10-4:30pm
III.	**Next Steps**	Information/ Discussion	4:00-4:15pm

Attachment:

- Minutes of December 9, 1998
  filed under - Minutes